DOCTOR OF PHILOSOPHY

Ethical decision making in the National Health Service

A theoretical analysis of clinical negligence with reference to the existential writings of Søren Kierkegaard, Emmanuel Levinas, and Jean-Paul Sartre.

MacLaren, Gordon

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Submitted By

Gordon MacLaren

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ASTRACT

Jean Paul Sartre proposed that:

> Historical situations vary…What does not vary is the necessity for him to exist in the world, to be at work there, to be there in the midst of other people, and to be mortal there. The limits are neither subjective nor objective, or rather, they have an objective and a subjective side. Objective because they are to be found everywhere and are recognizable everywhere; subjective because they are *lived*[1] and are nothing if man does not live them, that is, freely determine his existence with reference to them (Sartre 1987: 38, 39).

The Existential philosophy as outlined by Sartre, Levinas, and Kierkegaard cares about the lived experiences of individuals. Such a view is in contradistinction to other philosophical views which have a tendency to reduce human experience, or to lose the individual in abstraction.

This thesis has a central concern for the ethical care of patients in the National Health Service. In order to explore the concrete experiences of patients it is necessary to consider the care providers. To that end, the individual health professional then becomes the focus of study.

To assist in this approach a double narrative runs through the thesis, which comprises exploring ethical decision making in the NHS, and also on the legal concept of clinical negligence. These two concepts are intertwined in that legal hearings and rulings have a

[1] Emphasis in the original.

normative influence upon health care practice, and also influence public expectations. The explicit purpose of this approach was to ensure that the theory was explored and developed; grounded upon everyday clinical NHS practice, which includes legal and political influences.

The first four chapters of the thesis constructs the three main areas of analysis; Philosophical, legal, and political. With this framework established, the critical analysis of five legal cases of clinical negligence (Chapters Five and Six), establishes convergences in the work of Sartre, Levinas, and Kierkegaard in relation to the subject, freedom and the ethical.

The Kierkegaardian concept of *kinesis*[2] is applied to explore the transition from possibility to actuality in ethical action. During this process a range of dynamics are identified in creating the concept as best described by Levinas as *totalisation*[3] .

Where previously the argument was located at the individual (subject) and organisational (system) level, in Chapter Seven it moves outwards to consider how the authentic individual can create a civil society.

Given the recalcitrant barriers identified in the analysis, Chapter Eight considers existentialism as a theory of community and as contributing to epistemology. Together

[2] 'Movement'.
[3] Totalization involves the reduction of any form of difference to sameness for the purpose of enhancing the power of rationalization (Hutchens 2004:15).

these theories are proposed as addressing the real needs of individuals, by promoting their freedom, and achieving unity in diversity.

The recommendations in Chapter Nine are based upon the interplay of two main dialectics uncovered in the body of the thesis concerning ethics and epistemology. Deontology, Utilitarianism, and Virtue ethics were found to all contribute towards professional conduct. However, they were found to be insufficient because they reduce patients and health professionals' existence to the same as everyone else. Further, Virtue ethics reverses the way in which ethical behaviour is evaluated in comparison to the other two main normative theories. That is, behaviour is evaluated against the virtue being foundational, as opposed to the act performed. However, there is no discussion on how the individual health professional would decide which approach to use. All three approaches then lack a crucial factor which is the existential dimension. Existential ethics is then presented as a possible approach to facilitate the development (*kinesis*) of health professionals to the ethical sphere of care. Existential ethics emphasises the pre-theoretical aspect in caring for patients. That is, it appreciates the individual and their difference, prior to any conceptualization which has the potential to reduce individual difference to sameness. From this perspective recommendations are outlined for facilitating individuals to develop the ethical aspect of care, for health care pedagogy, and for leadership within the NHS.

CHAPTER ONE: INTRODUCTION & BACKGROUND

Background to the study.

This doctoral thesis developed from an undergraduate research study which explored the ethical behaviour of health professionals working in an intensive care unit. The study found 72% of the patients had an endotracheal tube cuff pressure[4] above the recommended safe pressure (MacLaren 1996). An education programme reduced the percentage of high endotracheal tube cuff pressures down to 44% of all patients. When staff were interviewed about the persisting high cuff pressures, they could provide high detail on the pathophysiology resultant on these pressures, but indicated that more visible aspects of care were of priority in comparison to the less visible cuff pressure (MacLaren 1996). The question then arose regarding the motivation for ethical behaviour. While the evidence base for this issue is now well established, the problem still persists, suggesting that this problem is more than solely an educational one (Sengupta et al. 2004, Shibasaki et al. 2012, Sole et al. 2011, Sultan et al. 2011).

High quality clinical care is delivered by an interprofessional health care team (Pethybridge 2004, Reeves et al. 2009, Kvarnström & Cedersund 2006). A collaborative team-based model of health care delivery has become increasingly valued over the traditional hierarchical model of medical dominance (Grumbach & Bodenheimer 2004, Wagner 2000, Leape et al.2009). As the literature review will later

[4] An endotracheal tube is passed into the trachea when a patient requires mechanical ventilation. In order for the tube to be air tight, a small balloon at the end of the tube (cuff) is inflated to achieve this airtight seal. The pressure should be maintained in the range of 20-30 cm H_20 (Sengupta 2004).

demonstrate- that while an epistemology of deductive reasoning and reductionist logic is still used by doctors in decision making-it tends to omit the other dimensions of personhood such as psychological, social, relational, and spiritual. This finding is significant given that the biopsychosocial model of care has been espoused by health professionals for more than three decades (Engel 1977, Engel 1980, Smith 2002). And yet, in 2010 key research studies are finding that medical staff focus upon the patients functioning and remove the existential meanings from the assessment (Agledahl et al. 2010). Such reductionism to the biomedical module '…involved a moral as well as a practical simplification (Agledahl et.al. 2010; 107)'. Importantly, the authors highlight that this is an '…integral part of clinical practice and not an individual flaw (Agledahl et. al. 2010; 107)'. One vital aspect of this process was termed 'Existential filtering' '…which took the focus away from the patients' private feelings and what the suffering meant to the particular patient (Agledahl 2010; 111)'

The moral domain of health care.

Health care has a moral domain precisely because medicine, nursing, and the allied health professions aim to relieve patients' suffering and to improve their health (Pellegrino 2001, Cronqvist et al. 2004, Kulju et al. 2013). The political influence of this moral aspect has been recognised since the inception of the National Health Service (NHS) in 1948. The then Secretary of State for health-Aneurin Bevan-stated "We now have the moral leadership of the world (Anon 1948)". This was in reference to the founding principles of the NHS. These pronounced that health care in the NHS would be; universal, equitable, comprehensive, high quality, free at the point of delivery, and centrally funded (National Health Service Bill 1946). Since its launch, the

history of the NHS has been one of reforms (Butler 2010, Klein 2010). Two landmark reforms moved the NHS philosophy to one of consumerism. The first was brought in by the Chief Executive of Sainsbury's which instigated general management into the NHS with the aim of making health services more business-like (Harrison 1990). The second, more radical reform was to introduce a quasi-market into health care (Greener 2002, Timmins 1995). The conservative Prime Minister Margaret Thatcher considered the NHS had become a '…bottomless financial pit… (Thatcher 1993; 608)'. While the internal market could contribute fiscally, little consideration was given in moving towards a market economy. That is, little thought was given to how splitting health authorities from hospitals, and making hospital trusts compete on the market for customers, would affect patient care, particularly on the moral domain.

The moral domain of teaching.

Similar reforms, influenced by a market economy, have changed the philosophy of higher education (Barnett 2011, Naidoo and Jamieson 2005). The dominant economic philosophy within higher education has become neoliberalism (Olssen & Peters 2005). It has introduced a new mode of governmentality with the commodification of teaching and research (Olssen & Peters 2005). Neoliberalism as the dominant economic discourse has placed universities on the open market, and as such has contributed towards the globalisation of higher education (Barnett 2000). Under such a managerial system teaching as a commodity is measured with performative criteria and valued in measurable outputs (Barnett 2000). Higher education has become part of the knowledge economy and the role of universities has become crucial to governments around the world.

Alasdair MacIntyre provides a helpful analysis of the university within this knowledge economy as an input-output machine (MacIntyre 2004, MacIntyre & Dunne 2002). According to MacIntyre the students, as raw material, are the input, and output is measured by exam results, number of graduates, and research publications (MacIntyre & Dunne 2002). However, the market economy sets up a dynamic within the university system due to the focus on outputs as the basis for competition. The market economy also sets up a dynamic due to industry[5] stipulating the required graduate competencies for the undergraduate curricula (Pellegrino 1999). The combining of these two pressures can influence teachers and students.

Schapper and Mayson (2005) propose that with the curricula prescribed and an outcome driven approach to teaching, academics become cast in the role of process labourer. With the emphasis on standardisation there is a risk of losing the internal goods[6] of the practice of teaching. Barnett supports this view by arguing that the bureaucratic system requires staff to '…subjugate their academic personae with the corporate persona… (Barnett 2011; 51)'. Barnett goes on to identify how the bureaucratic university affects the existential dimension of the lecturer; '…it limits academic identity, it corrals academic life into an undue uniformity, it allows no escape (Barnett 2011:56)'. The difficulty identified in MacIntyre's analysis is that those who lack the relevant experience of the practice 'are incompetent thereby as judges of internal goods (MacIntyre 2004: 189)'. A potential problem then arises where the

[5] NHS in this case.
[6] Alisdair MacIntyre distinguished between internal goods and external goods to a practice in *After Virtue* (MacIntyre 2004). Internal goods are defined as those goods which can only be had by engagement in the particular practice.

managerial system lacks insight to the goods of a practice such as teaching health professionals. Such a view would be supported by Hyland who argued that competence strategies 'underpinned as they are by technicist and managerial assumptions cannot accommodate the ethical and epistemological bases of professional practice (Hyland 1997:492)'. This is a significant point as Kreber identifies that it is 'only by exercising the virtues of justice, courage, and truthfulness that we can both sustain the standards of excellence that have historically developed within a practice and gain access to the internal goods of a practice (Kreber 2013; 85)'. When an individual has to subjugate their virtues, for the sake of prioritising the external good of a practice, questions then arise about *authentic* being within an organisation. This is one of the main existential themes which will be discussed in this thesis.

Introduction to Existentialism.

Given the subjugation of the existential dimension in both health care and in teaching, existentialism is being used as the main philosophical framework in this thesis to analyse how such a down-playing would affect the quality of care provided to patients.

Existentialism came to fruition following the Second World War. It became identified with a cultural movement that flourished in Europe in the 1940s and 1950s. Mróz (2009) explains that there are at least three basic connotations to existentialism; as a certain life style with a new way of interpreting the post-war reality, as an influence upon the art-world[7], and in its strict sense as a philosophy. While the first of these

[7] Some of the literary approaches, such as the use of the novel, and literary techniques such as the use of pseudonyms will be discussed later in relation to teaching ethics.

connotations is a passé event now, existentialism has continued influence upon the other two areas, i.e. in the art-world and in philosophy. As a philosophy it has further influenced theology and psychology.

While the nineteenth century Danish philosopher, Søren Kierkegaard (1813-1855), and German philosopher Friedrich Nietzsche (1844-1900), came to be seen as precursors of the movement, there were earlier origins to this theoretical outlook (Please see Appendix 5. p.436). Flynn proposes that existentialism, with its focus on the proper way of behaving - as opposed to an abstract set of theoretical truths- can be traced back to Socrates (469-399 BC) (Flynn 2006;1).

Existential philosophy selects a distinctive cluster of philosophical problems. In its acute phase this could be seen in the focus of trying to make sense of the reality of the war years, and then the postwar '…all-pervasive feeling of historical and personal crisis, of abandonment, this acute consciousness of the lack of moral or ethical orientation… (Mróz 2009; 127). It is this concern with *human* existence that delineates the area of philosophical inquiry for existentialism. From this perspective of the subjective, existing individual, existentialism claims that a new grammar is required, not found in previous philosophy, in order to understand the existing individual.

Existential philosophy was specifically selected as the main philosophy in this thesis because of its focus upon the existing individual. With its main themes of developing an individual self, having a concern for the moral domain of life, developing an

authentic self, and being free to act, it was considered an appropriate overarching dimension to appraise clinical practice within the NHS.

Søren Kierkegaard (1813-1855), Jean-Paul Sartre (1905-1980), and Emmanuel Levinas (1905-1995) were chosen because they each brought a unique perspective to the discussion on the ethical domain of health care. Although it is well recognised that they have opposing views on many of the main themes concerning the existing individual, this only proved to enrich the dialogue by having a creative dynamic from which to consider the different arguments. Some would even challenge that Levinas is not usually classed as an existentialist. The essential contribution from each of these provocative thinkers will now be discussed in turn, commencing with Kierkegaard.

Kierkegaard.

Søren Kierkegaard was a prolific writer both in theology and in philosophy. Two of the main critiques in his work are against the Danish church in his home town of Copenhagen, and the other was against his perennial adversary Hegel. In attempting to highlight the crowd mentality of the Danish church Kierkegaard developed the concept of 'Christendom' in contrast to an individual faith which would be Christianity (Hannay & Marino 1998). One of his main themes remains constant from this period; that of *movement*. The example he gave was that where 'Christendom' was *being*, where in comparison one *became* a Christian (Carlisle 2005). In addition to providing a negative critique on Hegel's all-encompassing philosophical system, Kierkegaard opposed the lack of movement in Hegel's philosophy; 'It is indeed curious to make movement the basis in a sphere in which movement is inconceivable or to have

movement explain logic, whereas logic cannot explain movement (Kierkegaard 1992a; 99 & 100)'. The existentialist[8] perspective then that Kierkegaard brings to this thesis is *movement* through his emphasis on *becoming* over *being*. '…ethics, which does not have the medium of *being* but of *becoming* (Kierkegaard 1992a; 421)'. This central theme will now be developed in discussing Kierkegaard's stages of existence.

The Stages of Existence.

For Kierkegaard, to exist means to take up a stance in relation to one's life and world. He argues in his work for a theory that begins with the individual's experience of existence rather from abstract philosophical systems such as Hegel's which arguably are unable to capture the existing individual. The 'stages' or 'spheres[9]' of existence are three main types of subjectivity; aesthetic, ethical and religious. As different types of subjectivity, they '…refer to 'how' one lives, rather than 'what one believes or does (Carlisle 2006; 75)'.

The purpose of distinguishing these spheres was to assist Kierkegaard's readers to reflect and to see the truth about their own individual existence. Carlisle explains that the stages are there to instruct sophisticated, educated readers who believe they already know what it means to be ethical (Carlisle 2006). The overarching schema of the

[8] Kierkegaard has a unique literary style to address the existing individual. Some of the features are that he speaks to the reader on a personal level. Due to the use of pseudonyms the reader is uncertain to Kierkegaard's own views. This literary technique is developed further in works such as *Either/Or* (Kierkegaard 1992b) where the reader is left to puzzle over the contrasting points of view expressed by the different opinions in the book. The final example would be where Kierkegaard wrote *Fear and Trembling* (Kierkegaard 1985) and *Repetition* (Kierkegaard 2009) under different pseudonyms and then they were published on the same day. Yet some suggest they should be read as companion pieces (Carlisle 2006 12).

[9] Kierkegaard switched from 'stages' to 'spheres' in his discussions of the aesthetic, ethical and religious forms of life (Carlisle 2006:86).

existential framework shows a movement towards 'interiority' or inwardness. As the stages are outlined below some of the central existential themes will be identified; freedom, authenticity, and the necessity to choose one's life. Kierkegaard summarizes this where he states;

'Ethics focuses upon the individual, and ethically understood it is every individual's task to become a whole human being, just as it is the presupposition of ethics that everyone is born in the state of being able to become that (1992a;346)'.

This proposition will first be considered in the first of the descriptions of subjectivity, in the aesthetic stage.

The Aesthetic.

Given that for Kierkegaard, to exist means to take up a stance in relation to one's life and world, it will be seen that the aesthete has a very weak sense of self. It can be seen from the table (Appendix 1.p.424) that the aesthete is characterized as being immersed in the world of immediacy and pleasure. Since Kierkegaard defines freedom as a person's power to become something, to have direction in their life, and to have the capacity to act, the aesthete lacks freedom. In relation to the health professional, the aesthete's only value is pleasure, so they are self-interested, and have not yet developed a self to care for others. As such they are uninterested in the ethical domain of health care practice for the ethical lacks excitement[10]; 'Beneath the sky of the aesthetic everything is light, pleasant and fleeting: when ethics come along everything becomes

[10] It will be proposed later that this stage is similar to Sartre's concept of *bad faith.*

hard, angular, an unending ennui[11] (Kierkegaard 1992b; 305)'. From this it can be established that the aesthete fails to recognize the ethical because they have not yet chosen this type of subjectivity.

The Ethical.

While Kierkegaard provides a negative critique of the aesthete, the overarching schema of the framework shows that the previous stage (aesthetic) is not completely abandoned, but rather is transformed in the ethical. Kierkegaard also points out that the stages are qualitatively different so it takes a 'leap' to make the transition between stages. In the movement from the aesthetic to the ethical, this is facilitated by irony which by self-undermining the individual helps them to see the aesthetic type of subjectivity untenable.

Crucially in the ethical stage the individual chooses good and evil/or excludes them. There is a change here in comparison to the aesthete in the area of decision making, in that the ethical stage the individual becomes seriously engaged with decision making. This includes the ethical individual taking responsibility for developing their self, and in turn they have a sincere concern for others.

Kierkegaard poses a significant problem in his work *Fear and Trembling* where he considers the Old Testament biblical story of Abraham being called to sacrifice his son Isaac (Kierkegaard 1985). Significantly, Kierkegaard defines the ethical as the universal;

[11] A feeling of listlessness and dissatisfaction arising from a lack of occupation or excitement.

> The ethical as such is the universal, and as the universal it applies to everyone, which can be put from another point of view by saying that it applies at every moment (Kierkegaard 1985; 83).

When the ethical is defined as the universal, as duty and obligation (Kant), and is concerned with acting for the sake of the community as a whole (Utilitarianism), the question arises if the ethical can ever be suspended? Kierkegaard replies that the ethical can be suspended for something else which lies outside of the ethical sphere. This would be the single individual as they stand in relationship to the Absolute. Kierkegaard calls this movement a 'teleological [12] suspension of the ethical' (Kierkegaard 1985; 83-95). While Kierkegaard explored this concept in theological terms, this theory of the teleological suspension of the ethical will be considered within the thesis in relation to whistle blowing, and justice for patients when the ethical system is called into question. It will be argued that while world religions do influence health care ethical debates, there is also the potential to see Kierkegaard's argument from a wider perspective, where the relation with the Absolute can potentially be faith in the health care system and its founding principles. Consideration of this view will be outlined in the religious stage below.

The Religious.

In many respects the 'Religious' term is a misnomer, and Kierkegaard spent most of his life highlighting its antonym, which would be personal, individual faith. This was Kierkegaard's position even when he was dying in hospital. At this time he refused a

[12] Teleological comes from the Greek word *telos* which means 'having reached its end, finished, complete (Liddell 1992; 797)'. It is commonly translated as end, purpose or goal.

visit from his brother who was a theologian and pastor. When his friend asked if he would like to receive the Eucharist, Kierkegaard confirmed that he would, but from a layperson because he considered pastors as civil servants of the Crown (Kirmmse 1998; 15). This is a continuation of Kierkegaard's distinction between religiosity (Christendom) and true faith (Christianity).

The role of world religions is discussed in the thesis in relation to decision making, and the hermeneutical challenge of interpreting ancient texts in a postmodern society. In the religious stage Kierkegaard offers a unique perspective on what the individual turns to in concrete situations when several rules/duties/obligations may all apply at once, when we are forced to 'choose *outside* any rule and from *inside* ourselves (Barrett 1990;168)'. This view anticipates Levinas' concept of *totalisation*; where the chief movement of modernity is a drift toward mass society, which means the death of the individual as life becomes ever more collectivized and externalized. Where Kierkegaard applied his critique to the possibility of region becoming institutionalized, it is applied in the thesis to the individual health professional within the NHS system.

Carlisle helpfully explains that although it seems clear that there is a progression from the aesthetic to the ethical to the religious '…I might move between all three within a single day (Carlisle 2006:87)'. These three stages of existence will be discussed in the corpus of the thesis in analyzing the cases of clinical negligence. First, they will be reviewed in conjunction with Sartre's ontology.

Sartre.

Jean-Paul Sartre (1905-1980) was not only a French philosopher, but his œuvre is a unique phenomenon as he has also been a major playwright, novelist, political theorist, and literary critic (Baldwin 1995). One of the major achievements in his philosophy concerns freedom to exist as an individual.

Prior to Sartre's work on existential freedom there had been a long standing debate between determinists-who believe that everything that happens is fully determined by what has gone before it-and the proponents of free will (Kane 2005). An extreme example of determinism within the world of physics was proposed by Laplace. He stated that;

> if a powerful intellect understood Newton's laws, and had a description of the current position and momentum of each particle in the universe, and the requisite mathematical ability, that powerful intellect could predict and retrodict every event in the history of the universe (Weatherford 1995; 195).

This thesis of determinism within physics was termed the 'clockwork universe' and it dominated the world of physics for two hundred years (Weatherford 1995). The greater concern for the current discussion is whether individual humans are subject to the same sort of determinism. The determinists would argue that we are the products of our upbringing and social conditioning, with genetic make-up and psychology influencing us.

In this way free will is seen as an illusion with everything that people do is causally or logically necessitated. Sartre, by contrast attempts to show that free will is an intrinsic and necessary feature of the human condition (Cox 2006). Without this existential freedom health professionals would not be responsible beings capable of choice. Nor would there be any requirement to think or to make decisions as there would be no real possibilities or alternatives. The structure of Sartre's existential freedom will now be set out below.

Freedom

Where Kierkegaard criticized Hegel for the lack of movement and the all-encompassing nature of his philosophical system, Sartre finds Hegel lacking on his theory of being (ontology). One of the key areas where Sartre disagrees with Hegel is where he thought that there is neither being nor non-being, only becoming. This is crucial to Sartre's work, and he makes it clear that this difference is what gives the individual freedom to be. Rather that the abstract 'clockwork universe' Sartre's chief concern was with the truth of the lived experiences of people as they struggle with the obstacles of other people who are for and against them, and to have free will in a world where economic, social, political and cultural structures serve to impede rather than support individual flourishing. In contrast to Kierkegaard, Sartre was an atheist and as such rejected any theological structure that would suggest any predetermined values in the world. In so doing Sartre emphasized freedom to make decisions as the source of value lies in individual's choices. The locus of the moral problem thereby changes to being a human problem which confronts us individually as personal responsibility. Similarly to Kierkegaard, Sartre insisted that individuals are responsible for what they

make of themselves-regardless of the situations they find themselves in[13]. This relationship between being and non-being (nothing) is central to his entire philosophy, and serves as a consistent thread in exploring his complex system. The overarching existential schema will now be described.

Sartre's theory of freedom is set out in three modes of consciousness. They are named *being-in-itself, being-for-itself,* and *being-for-others.* The focus of the discussion will be on the *in-itself* and *for-itself.*

Being *in-itself* is unreflective. It is what the individual is before they begin to think about what they are. The true role within the structure of being for *in-itself* is best uncovered in comparison to the *for-itself.*

Being *for-itself* is that mode of consciousness which think's about the *in-itself.* As such it is that mode of consciousness which considers its being. By being able to reflect upon the *in-itself,* the *for-itself* has a constitutive role in that it can imagine how the *in-itself* could develop in the future. For Sartre the existing individual is the relationship between the *in-itself* being (the thing I am), and the thinking about of the thing I am (*for-itself)*; consciousness of being. Since –according to Sartre - we are not predefined in any way, individuals are free to develop their being and to define their existence. Such acknowledged freedom causes *anguish*, and one main way to resolve this anguish is to live in *bad faith* where the *for-itself* attempts to not choose itself.

[13] Sartre was a prisoner of war and yet even towards the latter years of his life he maintained that 'in the end one is always responsible for what is made of one'.

Sartre's overarching existential schema is applicable to this thesis as it provides structure in exploring if health professionals have freedom to exist as individuals. It provides an existential grammar to consider if health professionals struggle with the existing-in-situation with the potential for *bad faith.* Sartre identifies two types of *bad faith*. One where the individual tries to escape the anguish related to the freedom to define their existence. The other is where the individual discounts their antecedent condition-which includes facticity-as if they were pure possibility, living in the future, uncumbered by any past. Both forms of bad faith are unrealistic about the human condition by insisting it is either transcendence *or* facticity, when in fact it is both. Those who choose the challenge to live this truth about their condition are said by Sartre to be 'authentic'. The authentic person is an individual, not just part of the crowd, or as will be seen in Levinasian terms *totalised.*

Levinas.

The Lithuanian-French philosopher Emmanuel Levinas (1906-1995) proposed the need for thinking beyond ontology. In *Totality and Infinity* (2008) Levinas provides a critique of western philosophical thought and practice, which he considered to be a striving for *totalization*. This is one of the key concepts in Levinas' work which means the universe is reduced to an origin and unity due to panoramic overviews and dialectical syntheses (Peperzak 1996). Writing against such Western totalitarianism Levinas maintains that the human and divine Other cannot be reduced to a totality of which they would only be elements.

Levinas was a pupil of Husserl and Heidegger and was therefore influenced by their work on phenomenology. Indeed, Levinas's work is deeply indebted to the Husserlian theory of *intentionality*, with the most significant aspect being his contestation of the ethical implications of its epistemolgical account of intersubjectivity. Levinas considered Husserl's intentionality as privileging a representational model of consciousness. In other words, every objectifying act is necessarily either a representation or founded on a representation;

> Yet already with the first exposition of intentionality as a philosophical thesis there appeared the privilege of representation. The thesis that every intentionality is either a representation or founded on a representation dominates the *Logische Untersuchungen*[14] and returns as an obsession in all of Husserl's work (Levinas 2008;122).

At the heart of Levinas' philosophy is a reversal of Husserl's theory of intentionality. By enacting this reversal Levinas inaugurates a new style of phenomenology, and places a new emphasis on ethics by pronouncing 'Ethics as First Philosophy (Levinas 2009a)'. Since this distinctive account of the ethical is so crucial to this thesis, intentionality will first be explained, and then Levinas' reversal of Husserl's intentionality will be discussed in relation to his face-to-face encounter with the Other. Firstly, intentionality will be briefly explained.

[14] Edmund Husserl. *Logical Investigations.* Published in 1900-01.

Intentionality.

Intentionality has been central to discussion within philosophy in the context of ontological and metaphysical questions about the fundamental nature of mental states such as perceiving, knowing, and experiencing (Jacob 2010). The philosopher and psychologist Franz Brentano revived the term from medieval philosophy in 1874 when he defined it as 'the direction of the mind on an object (Crane 1995; 412)'. The word intentionality comes from the Latin *intentio*, from the verb *intendere*, which means 'directed towards some goal or thing (Jacob 2010)'. Intentionality then is a characteristic feature of our mental states which are evident in what we commonly call being 'conscious' or 'aware'. Examples would be when we-as conscious beings- are *conscious of* physical objects or other people. In this way each such mental experience is a *representation* of something other than itself and so gives a sense of something.

Husserl's interest in intentionality was inspired by his teacher Brentano. Although Husserl placed great emphasis on the lived experience (*Erlebnis*) he continued to maintain that practical acts are necessarily founded on cognitive presentations. According to Levinas this elevation of the theoretical mode of intentionality leads to an intellectualism. Peperzak claims that in this sense Levinas characterizes Husserl's philosophy as an 'objectifying' or 'representationist' mode of thought (Peperzak 1997).

Levinas' reversal of intentionality-the *face-to-face.*

Cohen helpfully emphasizes that the *face-to-face* encounter between the self and the other person, is not a concept, rather it is a concrete reality, which actually occurs with

all the particularity of the Other (Cohen 2007). Konopka perceptively identifies, that Levinas' reversal of intentionality '…was never meant to render intentional analysis null and void, but *to search for a prior relation of transcendence*[15] not proper to acts of objectification (Konopka 2009;150)'. Levinas uncovers this relation *prior* to concepts and *prior* to Husserl's intentionality. This feature is seen in his conversation regarding *face* with Philippe Nemo, where Levinas explains; 'The relation with face can surely be dominated by perception, but what is specifically the face is what cannot be reduced to that (Levinas 2007; 85 & 86)'.

Levinas identifies the potential limiting dynamic of intentional analysis-applying concepts to the other person-where I want to control the other person for my purposes or ends. The power of such an epistemology can be seen where Levinas pronounces;

> But in knowledge there also appears the notion of an intellectual activity or of a reasoning will-a way of doing something which consists precisely of thinking through knowing, of seizing something and making it one's own, or reducing to presence and representing the difference of being, an activity which *appropriates* and *grasps* the otherness of the own (Levinas 2009b: 76).

The face-to-face encounter resists this grasp, classification, and domination. However, Levinas details the vulnerability of the other in terms of being 'weak', 'poor', 'the widow and the orphan', 'whereas I am the rich or the powerful (Levinas 2009b:48)'. As a result, Levinas locates the non symmetrical nature of the relationship at this juncture, and in other terms names it a break in the horizons of everyday experience;

[15] Emphasis added.

> The expression the face introduces into the world does not defy the feebleness of my powers, but my ability for power[16]. The face, still a thing among things, breaks through the form that nevertheless delimits it. This means concretely: the face speaks to me and thereby invites me to a relation incommensurate with a power exercised, be it enjoyment or knowledge (Levinas 2008:198).

With this fundamental encounter with the Other established, Levinas then develops, repeats, and refines the formulation in order to open our eyes to this hidden aspect of everyday life (Morgan 2011). Some of the significant aspects which will be developed in the body of the thesis are from his essay 'Is Ontology Fundamental? (Levinas 2006)'. In contrast to the more usual asymmetrical relationship within healthcare - where the nurse or doctor have dominance over the patient due to their superior knowledge and skills of the health condition- Levinas states the relation occurs in the vocative[17] (Levinas 2006). This *call* from the Other is prior to epistemology, ontology, and even philosophy[18]. Due to this *call* being a command it cannot be ignored. Rather, Levinas develops the hold this call has over me, and states it will hold me *hostage.*

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[16] "Mon pouvoir de pouvoir." This footnote is in the original text.

[17] Latin. *vocativus* from *vocare* which means 'to call'. Vocative is a case of nouns, pronouns and adjectives in Lain and other languages, used in addressing or invoking a person (Soanes & Stevenson 2003; 1973).

[18] Levinas strictly maintains his arguments within philosophy. However, some of his ideas are perhaps easier to see within theology. An example would be where Levinas seems to present paradoxes such as the Other being 'weak', 'poor', an 'orphan', and yet at the same time having *height*, *infinity,* being able to 'command', and that there is a *trace* of the absolute Other in the Other (person) (Levinas 2008:251). This is best seen within Judeo-Christian theology of the Incarnation where God took on human flesh in the form of the second person in the trinity; Jesus Christ (Berkhof 1981; 333). The detail of Levinas' paradox is clear in the New Testament-Matthew 25. Jesus is judging nations based on how they have helped the hungry, thirsty, naked, and sick. When the question is posed of when any individual could have ever welcomed Jesus as a stranger, naked, sick or in prison, the answer is given; 'Truly, I say to you, as you did it to one of the least of these my brethren, you did it to me'. In this way, due to the *trace* of God in each individual person, they can be poor and hungry, but they also have the trace of the infinite in them (*height*).

This reversal of intentionality and the focus upon the relation with the Other allows Levinas to develop a new phenomenology (Crowell 2012). This new view can be seen where Levinas proposes;

> …Already *of itself* ethics is an "optics[19]". It is not limited to preparing for the theoretical exercise of thought, which would monopolize transcendence. The traditional opposition between theory and practice will disappear before the metaphysical transcendence by which a relation with the absolutely other, or truth, is established, and of which ethics is the royal road (Levinas 2008:29).

The foundation of this relationship towards the other is ethics;

> 'We name this calling into question of my spontaneity by the presence of the Other ethics. The strangeness of the Other, his irreducibility to the I, to my thoughts and my possessions, is precisely accomplished as a calling into question of my spontaneity, as ethics (Levinas 2008: 43)'.

The calling into question of my spontaneity occurs in the call of the human face. This ethical perspective from Levinas is explored in relation to legal responsibility during the analyses of the legal cases of clinical negligence.

Levinas and Sartre. Differing perspectives on the human encounter.

The *face* as outlined above is distinctly different from Sartre's *The Look.* By considering the two ways of encountering the Other, it can be seen that Levinas' phenomenology has developed from Sartre's work, particularly on *Being-for-the others.*

[19] From the Greek *optikos* from *optos* 'seen' (Soanes & Stevenson 2003:1236). Allows us to see.

Consideration will now be given to these encounters, commencing with Sartre's being *for-the other*.

Being-for-the-Others.

Sartre's being *for-the Others* will be discussed in the thesis as this mode of being can limit the health professionals' identity. It occurs when the individual experiences themselves as seen by the Other, or when they can imagine themselves from the point of view of the Other. Sartre develops this phenomenon of encounter through a series of vignettes in Being and Nothingness (Sartre 2000).

The first vignette that Sartre introduces involves seeing a man in an empty park. Where previously the individual was alone in the park they could view the park from their own view (Solipsism). However, the awareness of the man's presence in the park affects the individuals situation, in that there is a disintegration of the of the world from my own point of view;

> Thus suddenly an object has appeared which has stolen the world from me. Everything is in place; everything still exists for me; but everything is traversed by an invisible flight and fixed in the direction of a new object. The appearance of the Other in the world corresponds therefore to a fixed sliding of the whole universe, to a decentralization of the world which undermines the centralization which I am simultaneously effecting (Sartre 2000: 255).

Sartre portrays this situation of the reorientation of the world towards this man as 'a kind of drain hole…' where my world 'is perpetually flowing off through this hole

(Sartre 2000; 256)'. The relevant fact is that the Other is a threat to my centralization and can cause a radical reorientation of my being.

In the second vignette Sartre portrays a voyeur at a keyhole. While on his own and involved in his actions the individual is in a solipsistic consciousness (*Being-in-itself).* The *look* changes the mode of being;

> But all of a sudden I hear footsteps in the hall. Someone is looking at me! What does this mean? It means that I am suddenly affected in my being and that essential modifications appear in my structure… (Sartre 2000; 260).

The *look* from the Other[20] effects a change in the situation, in that the individual becomes an object for the Other's subjectivity. Consequently, the Other becomes a threat to the individual's freedom due to this objectification. This is because when the individual experiences himself as seen by the Other he immediately ceases to be a transcendent subject (Linsenbard 2010). Sartre argues that conflict is necessary in this situation as the individual attempts to reclaim their self as seen as their project in the world. While it was previously identified above that there were two types of *bad faith* relating to the individual, *bad faith* can also involve attempts at objectifying the Other in an attempt to degrade the Other's assessment of me (Linsenbard 2010;63). This mode of being will be discussed in the thesis in relation to the existential freedom of health professionals.

[20] Sartre explains that it does not have to be a physical look from two eyes, 'But the look will be given just as well on occasion when there is rustling of branches, or the sound of a footstep followed by silence, or the slight opening of a shutter, or a slight movement of a curtain (Sartre 2000;257)'.

Crucially for phenomenology, Sartre discovers that the '…experiencing the Other as subject cannot begin with our experience of some particular thing in the world. It must begin with how I experience *myself* as an *object*[21](Crowell 2012; 11). Sartre's account of the Other's subjectivity clears 'the way for Levinas to reverse the terms of the traditional priority of ontology over ethics (Crowell 2012; 11).

The focus of the study.

In his book, After Virtue, Alasdair MacIntyre provides the scenario where the world of natural science suffers a catastrophe, where a Know-Nothing political movement destroys much of the systematic research process underpinning knowledge, to the extent that only fragments remain. Significantly, people continued to use the technical language of science:

> The hypothesis which I wish to advance is that in the actual world which we inhabit the language of morality is in the same state of grave disorder as the language of natural science in the imaginary world which I described. What we possess, if this view is true, are the fragments of a conceptual scheme, parts which now lack those contexts from which their significance derived. We possess indeed simulacra of morality, we continue to use many of the key expressions. But we have - very largely, if not entirely – lost our comprehension, both theoretical and practical, of morality (MacIntyre 2004:2).

[21] Emphasis in the original.

Most importantly MacIntyre goes on to emphasise ‘What would appear to be rival and competing premises for which no further argument could be given would abound (MacIntyre 2004: 1 & 2)’.

The aim of this research was to explore MacIntyre’s hypothesis within health care. That is to evaluate the extent to which there are fragments of differing moral frameworks within health care theory and practice.

The research was undertaken using existential philosophy as the main evaluative framework.

Main Hypothesis.

The main hypothesis of this thesis holds that health professionals are not existentially free when they care for patients within the NHS. In other words, they lack existential autonomy to provide the highest quality of care.

Main proposition.

This thesis proposes to put forward an existential ethics developed from the philosophy of Kierkegaard, Sartre, and Levinas as an alternative way of caring for patients within the NHS.

This thesis is set out in the following chapters;

Outline of Chapters

Chapter One. Introduction & Background

Chapter Two. Research Method

There are two main methods used in this thesis. The overall theoretical method is outlined first in section 2.1., and the specific method used to analyse the legal transcripts is provided in section 2.2;

2.1. Theoretical Analysis

In this section the main method used in the theoretical analysis is explained. Specifically, the method is one of what could be termed, ethical-existence phenomenology. The main philosophers considered in the body of the thesis are introduced.

2.2. Legal Analysis

An outline is provided in order to contextualise clinical negligence within the law of Tort. This section explains the specific method of the Black-letter approach used in Case law. It then concludes by detailing and justifying the selection of the ten legal transcripts on clinical negligence for analysis.

Chapter Three. 'Evidence in Ethical Decision Making.

This chapter takes up Levinas' proposal that ethics is first philosophy. It explores the dominance of empirical 'evidence' in comparison to other ways of knowing.

Chapter Four. Literature Review and Philosophical Analysis of Ethical Decision Making.

With the overall method set out in chapter two, this chapter reviews the research literature on ethical decision making within the National Health Service, from a multiprofessional perspective. Chapter Four then develops to provide a concept analysis of the various terms used to denote decision making. Here, it is made explicit that there is no generally agreed definition at the intra-professional level, that key variables such as the time available, and how well structured the problem is, influence the approach taken at the inter-professional level. From these research findings, a conceptual framework is formed upon the work of Hamm (1988). The purpose of this conceptual framework is to provide a focus from which to discuss how decisional theory articulates with the three classical moral theories of deontology, consequentialism, and virtue ethics.

Whistle blowing

Through the theory already reviewed on decision making, this section aims to consider why some professionals know of dangers to patients but keep silent, others raise concerns and are ignored, while yet others raise concerns regardless of the hostility or prolonged nature of the whistle blowing. This aim is fulfilled by firstly considering the etymology of the term, and a concept analysis performed on various permutations on the definition of whistle blowing. Some high profile whistle blowers found in the public press are then critically reviewed. Such cases as, Graham Pink, Beverly Allitt, the Personality Disorder Unit at Ashworth Special Hospital, Rodney Ledward, the

consultant anaesthetist; Dr Stephen Bolsin at Bristol Royal Infirmary, Alder Hay, and Dr Harold Shipman. In conjunction with the research, these paradigm cases reveal seven common major themes within the concept of whistle blowing. These themes are then considered in turn with a theoretical framework proposed by Van Es and Smit (2003) which allows exploration at the three different moral domains of public, organisational, and personal ethics. The chapter concludes with a summary of the key findings. This includes where Rennie and Crosby found that the number of medical students prepared to whistle blow declined in the later year groups of the course (Rennie and Crosby 2002). Significantly the literature also demonstrates how there is under reporting of error due to the fear of reprisals. It also identifies the slow insidious process of change into poor clinical practice.

With the theoretical bases from legal theory, ethical decision making, and whistle blowing now established, chapters four and five are conjoined to provide a theoretical analysis of ten cases of clinical negligence occurring within the National Health Service.

Chapter Five. Free to be condemned?

This chapter moves the discussion of ethics from the clinical area into the legal system. The discussion is set up to consider the extent to which morality is allowed to pervade the legal process. In order to do this an outline is provided of the three predominant approaches within jurisprudence which include; Legal positivism, Natural law, and law as interpretation. In order to consider the challenges of interpreting legal and religious texts, the development of hermeneutics is explored from the political perspective of the

German political theorist Carl Schmitt (1985), and philosophical perspective of Frederich Schleiermacher (1998), and Martin Heidegger (1999). With this groundwork in place, the analysis then commences on the first of the legal transcripts on clinical negligence. The clinical practice and legal process is evaluated against the ethical framework set out in the work of Kierkegaard, Levinas, and Sartre, with the key concept of *kinesis* being particularly evaluated, that is, the extent to which individuals move from non-being, to a being that is responsible for the other[22].

With this analytical framework in place, the chapter identifies a number of potential weaknesses within the legal system. It is argued that the judges are dependant upon the role of Expert Witness due to the rapidly developing technology within the NHS, but such a system is vulnerable as it is almost beyond judicial endeavour to understand this expert evidence. Judicial reasoning is further scrutinised by considering Kant's transcendental metaphysics in relation to *determinant* and *reflective* judgement (Kant 1987), before the chapter concludes with considering the influence of the quasi-market on the delivery of health care.

Chapter Six. Either/or; The Authentic Individual

Chapter Six continues with the analytical framework established in the previous chapter, and now moves on to consider a further seven legal cases of clinical negligence. This chapter argues for an authentic way of being for professional health care staff. The argument provides evidence of where clinical guidelines are not followed, and NHS regulators and NICE are bypassed. Where the Evidence Based

[22] The concept of *kinesis* in the work of Kierkegaard, Levinas, and Sartre is being proposed in this thesis. It is a concept which is not immediately associated with these thinkers.

Practice is a major philosophy, this is a significant undermining of the prevailing philosophy within the NHS.

Kierkegaard and Sartre's ontology and ethics is analysed in more detail, against the background of the legal cases reviewed. One of the main discussions regards the placing of financial ends as the focus of decision making. This is considered in relation to the case of Ann Marie Rogers and the funding of *Herceptin*. The concept is traced out further in the work of Polanyi (1999) where it was found that some of the cases were decided on the basis of the financial impact rather than notions of justice for the patient. Such cases were found to contain Polycentricity.

The argument concludes by emphasising the importance of the individual having a self to be responsible for the other, and of having a self that is developed for emotional involvement with vulnerable patients.

Chapter Seven. Contemporary Ethical Issues: A Survey of *Aporiai*

Chapter Seven takes some of the key legal issues identified in the previous two chapters during the analysis of the court transcripts, and focuses upon them from the political aspect. The main concern in this chapter is the relationship between the citizen and the state. The chapter is structured by providing an overview of the concept of sovereignty, before identifying five *aporia*. That is where five areas which should support ethical action, end with fossilisation of the individual in the system. The argument moves from a traditional view of sovereignty within a defined territory, to the supranational level of European law. The chapter concludes with a sketch of Kierkegaard's view of a civil society as a comparison to the situation analysed.

Chapter Eight. Existentialism at the Im/passé

This chapter draws together some of the main problems identified in the previous chapters. The argument is structured by firstly providing a literature review and concept analysis on existentialism, before outlining the concept of historicity from Heidegger. This then allows for a contrasting discussion from Heidegger's historical context through the notion of *tradition*, to the proposal of existentialism as a potential way to care for patients. The argument identifies the change of perspective contained within existentialism caused by being conscious of the infinite in relation to the finite. From this perspective, existentialism is then evaluated in its potential contribution towards jurisprudence, epistemology, and political theory. The chapter closes by returning to some of the cases of whistle blowing and links the discussion on totalisation to the importance of having a self in order to care for patients.

Chapter Nine. Conclusion: Existential Ethics

This concluding chapter critically reflects upon the dual narrative running through the thesis on ethical decision making and the influence of the legal system in serving justice in cases of clinical negligence. It rehearses on one final occasion, some of the weaknesses in consequentialism, principlism, and deontology as a way to inform and guide ethical care. Kantian deontic theory is appraised within the legal and health care systems as a codification of ethical behaviour, acting –in conjunction with the Evidence Based Practice paradigm – to provide norms which should be followed with unquestioning duty.

By placing emphasis on the pre-theoretical aspect of caring for patients, existentialism has uncovered some weaknesses in the current ethical convention. The normative and virtue approaches to ethics all contribute towards professional conduct, but a crucial aspect is lacking. This is the existential dimension.

The current convention reduces the professional conduct of health professionals to the same as everyone else's. This chapter identifies some of the theoretical underpinnings for this situation, and goes on to make recommendations for an authentic way of caring for patients.

CHAPTER TWO: RESEARCH METHOD

Introduction

The preceding chapter (Introduction & Background), set out the main hypothesis of this thesis, as one which will explore the extent to which health professionals are existentially free to make ethical decisions pertaining to patient care. It argued for existentialism as an approach which might fruitfully explore questions around the ethical aspect of healthcare. This argument was premised upon the objective and speculative approach to metaphysical philosophy failing to capture what it is to exist-as a patient, nurse, or doctor. The existentialism of Kierkegaard, Levinas and Sartre were then set up in contrast to this negative critique, in order to highlight ethical questions as being essentially first-person, and the real subject in ethics being the existing subject.

With the historical development of existentialism established in the previous chapter, this chapter is concerned to explain the further development of existential phenomenology as a particularly suitable practice of phenomenology to address the main research aim. It will also discuss why this *expanded* version of existential phenomenology is a particularly suited research method to explore the ethical domain of the lived experience of patients and health professionals.

The main problem in establishing a suitable method was due to the interdisciplinary nature of the study encompassing the fields of healthcare, law, and philosophy. Each of these disciplines has its own epistemological paradigm, with science for example considering how we *do* act, and normative ethics with how we *should* act (Loughlin

2011). Even within some of these disciples there are epistemological paradigms that are given unfounded predominance, for example, Evidence-based medicine (Henry et al.2007). Notwithstanding these challenges there is a call within the healthcare literature for research methods which are interdisciplinary in nature, and where philosophy has an '…indispensable contribution to make to the discussion of practice…' and '…the problems of practice provide the proper context for real progress in philosophy (Loughlin et al 2011; 840)'.

The following sections in this chapter will outline the rationale for the approach which became the final research method;

- Overview of the research method,
- Literature Review (1),
- Literature Review (2),
- Legal Analysis,
- Philosophical Analysis,

OVERVIEW OF THE RESEARCH METHOD.

In order to address the main research aim concerning existential freedom, two literature reviews were carried out. This allowed for an empirically informed philosophical analysis. The first focuses upon published research in healthcare journals on the topic

of healthcare ethical decision making and whistle blowing. The second reviews original law court transcripts involving clinical negligence.

The literature reviews were planned so that the findings of the healthcare literature would aid the philosophical analysis performed on the legal transcripts. The two levels of analysis performed on the legal transcripts are the legal analysis which was performed first, and then the philosophical analysis (existential phenomenology) which was performed separately, and following the legal analysis. This is summarised in figure 1, below.

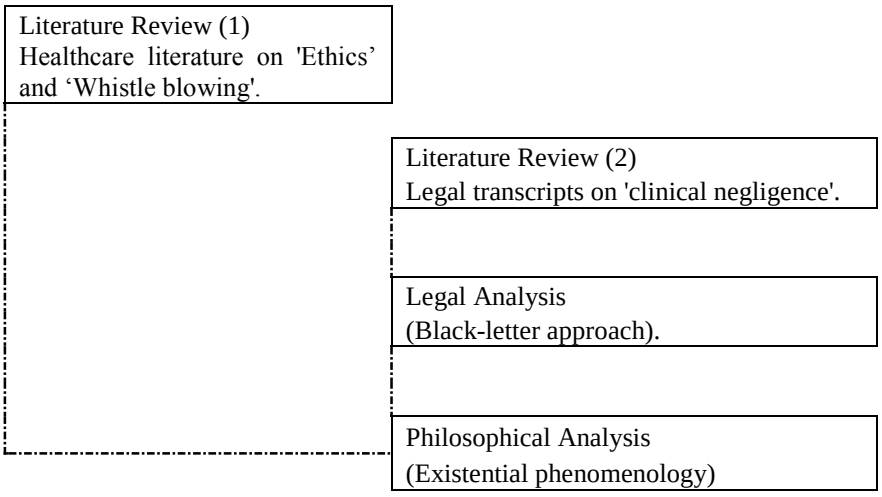


Figure 1. Overview of research method.

LITERATURE REVIEW (1).

A literature review was carried out on the empirical research within healthcare journals on key concepts related to the freedom of health professionals being able to act. Research studies were located using the electronic databases of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and on MEDLINE. This reviewed key topics such as 'ethical decision making', 'ethical sensitivity', 'moral distress', and 'Whistle blowing'. These latter two concepts were important in reviewing what health professionals would do when they felt health care fell below an acceptable, safe bench-mark.

This literature review established the main philosophical underpinnings to healthcare ethics as deontology, teleology, and virtue ethics. The findings of the literature review were analysed by MacIntyre's assertion that our vocabulary for morality is fragmentary where rival and competing premises are put together without any further discussion regarding the coherence of the theory.

The findings of this literature review were then used in the philosophical analysis of the legal transcripts of clinical negligence.

LITERATURE REVIEW (2).

Introduction

The second literature review is based upon legal transcripts of court hearings on cases of alleged clinical negligence within the NHS.

Legal transcripts are produced from shorthand notes taken during the trial. However most courts now have a specialised machine with a phonetic key system, or digital recordings. These notes or recordings are then transcribed into longhand by employees of legal firms who are contracted for this purpose. The transcripts provide an exact and unedited record of every spoken word, with each speaker indicated (Knowles 2012).

For research with a focus upon the existential freedom of individuals this is a very rich resource because the verbatim statements of nurses and doctors are provided in detail, concerning their *lived experience.* It was these legal transcripts which were the primary sources in this literature review.

The following section will explain the process of legal research and the selection criteria for the cases chosen for critical analysis, before moving on to the method of legal and philosophical analysis.

Legal Research and Case Law

Legal research, in a similar fashion to any research, is the systematic process of identifying and retrieving information necessary to support legal decision making (Salter 2007). This study has used an iterative approach between primary and secondary legal authorities. The primary sources are composed of the verbatim texts of case law obtained principally through the electronic databases of ‘Westlaw’ and ‘NexisLexis’. These are then cross referenced in books called Case Reports or Reporters. Secondary sources consist of legal opinion published in journals.

Since the court system is hierarchical a ‘case’ starts in the ‘court of first instance’ and can progress through appellate courts. Each time a case goes to court the proceedings are recorded verbatim and then published in Reporters and electronic databases. In a similar fashion to a research paper each case is published in a specific framework which provides information in a standard format on the Citation, Parties involved, Court, Hearing dates, Summary, Legislation and previous cases referred to, and the Decision (Thomas 2006). In this way a case remains live until the time for granting a re-hearing has passed (Elias & Levinkind 2005).

Within each case the *Ratio decidendi* (the reason for the decision) is explained in detail with numerous citations to previous decisions and other legal authority (Woodley 2005). Via this process we can see how Dworkin challenges legal positivism and instead argues that a judge does not make law but instead interprets what is already part of the legal materials (Dworkin 1998). The authors of Autopoietic theory go further by proposing that the legal system is similar to the typical biological system which is self-replicating, and where the initial properties of a member of one generation are controlled by properties of members of the preceding generation (Teubner 1993). Autopoietic theory was originally developed by Maturana and Varela (1991) to explore the individual organism and to explain the particular nature of *living* as opposed to *non – living* entities. Niklas Luhmann (1995) developed the theory to make autopoiesis the basis of his social theory. When this theory has been applied to the legal system it assists in understanding the independence and autonomy, - or the degree of closure - ,

in the legal system[23]. Further, it helps to distinguish from collective and individualised regulation where the two may co-exist, but where they are analytically distinct and therefore raise significantly different notions of justice.

This is a pertinent theory as jurists also change what was previously background text in previous citations (*Obiter dictum)* into a binding precedent in the form of *Ratio decidendi*. In this way the law is said to be operationally closed. Both approaches will be useful in analysing the legal transcripts for the degree to which law is autonomous or socially conditioned.

Selection criteria for the Legal court transcripts.

The legal research has been found by using the National Health Service Litigation Authority website (NHSLA) which is a Special Health Authority as part of the NHS and is responsible for handling negligence claims made against NHS bodies in England. NHSLA provides statistical reports on the breakdown of negligence claims made, which provides a framework for developing a representative sample for research on such claims. NHSLA presents 5,697 claims of negligence being filed in 2005-2006, with £560.3 million being paid out on these claims.

[23] Closure is defined as where all legal procedures always reproduce the system.

Figure 1. Total number of reported CNST (Clinical Negligence Scheme for Trusts) claims by specialty at 31/03/06 (since the scheme began in April 1995, excluding "below excess" claims handled by trusts)

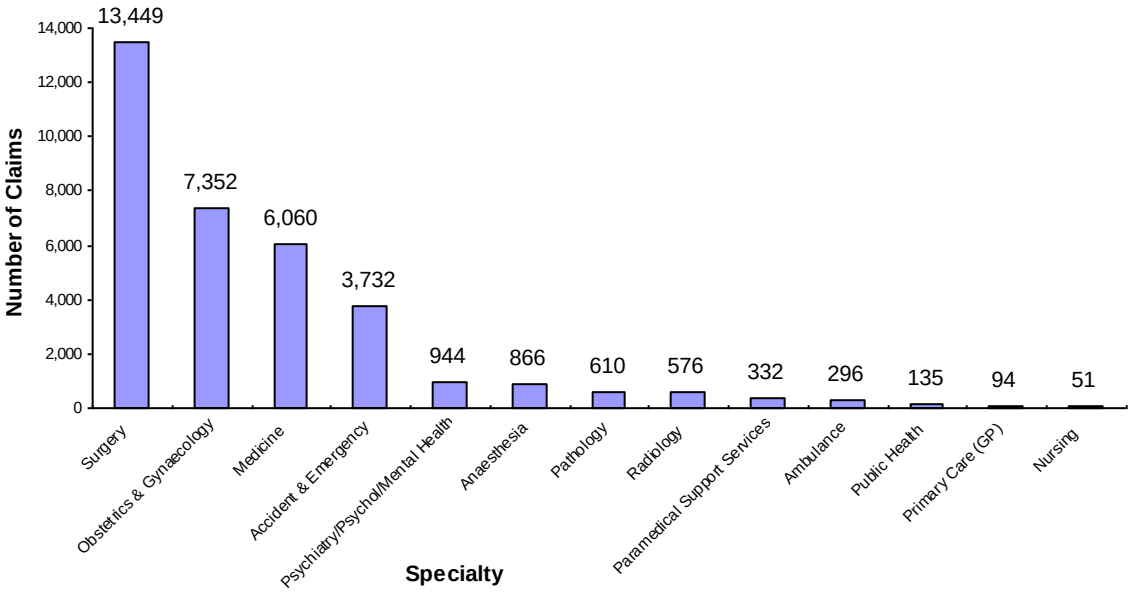
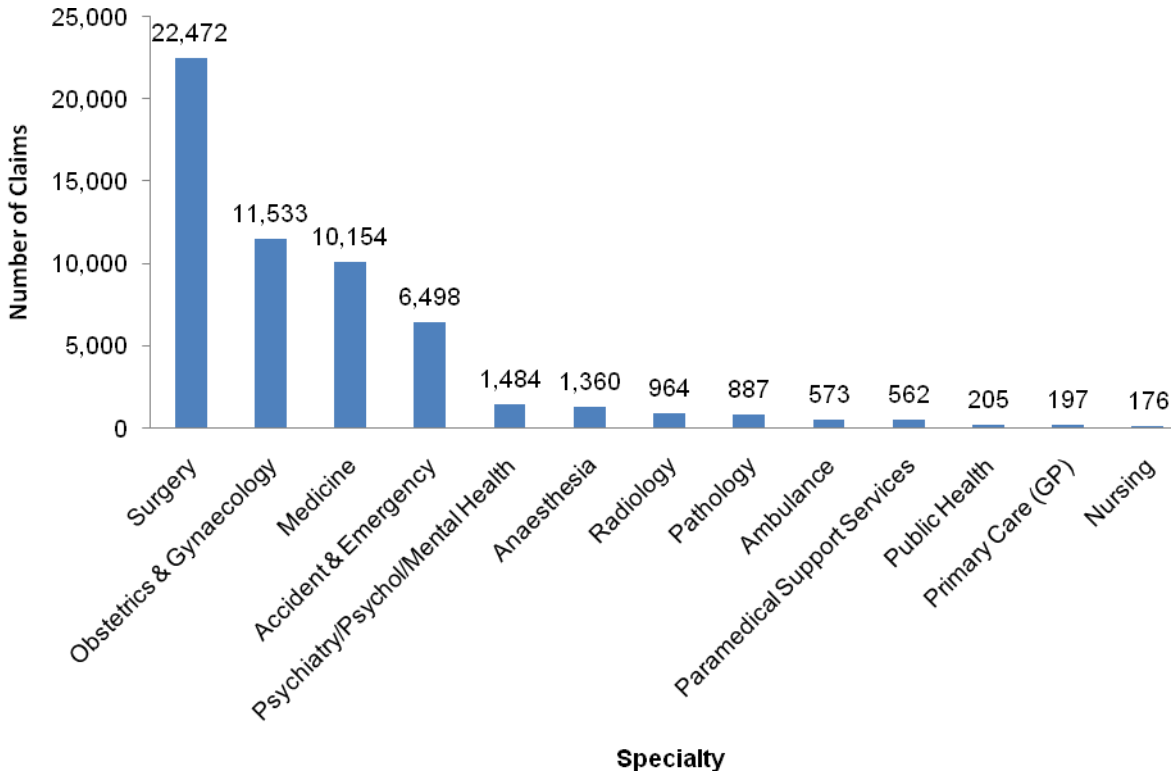


Figure 1 provides a breakdown of the clinical groupings of these claims of negligence. From this information five main groups were used to identify cases documented in legal court transcripts.

The statistical data produced by the NHSLA was reviewed throughout the research period, and finally evaluated in 2011. It will be seen from the graph below (Figure 3) that the groupings selected for study have not changed. The most recent report concludes;

> In 2009/10, 6,652 claims of clinical negligence and 4,074 claims of non-clinical negligence against NHS bodies were received by the Authority, up from 6,088 claims of clinical negligence and 3,743 claims of non-clinical negligence in 2008/09. £787 million was paid in connection with clinical negligence claims during 2009/10, up from £769 million in 2008/09(NHSLA 2011).

Figure 2. Total number of reported CNST claims by specialty as at 31/03/10 (since the scheme began in April 1995, excluding "below excess" claims handled by trusts)



While the cost in pure financial terms is significant-especially in the way the funding for damages will be diverted from funding the NHS-the impact upon public confidence is of equal importance. From the table below (Figure 3) it will be seen that some £550 billion pounds was diverted from the NHS in the period 2007-2008.

Figure 3. Funding for damages. (NHSLA)

Year	Damages awarded	Defense legal Costs	Claimant legal costs	Total
2005-2006	£412,245,050	£53,894,083	£91,252,864	£557,391,997
2006-2007	£332,786,934	£49,808,394	£83,830,905	£466,426,233
2007-2008	£384,841,737	£56,848,517	£108,921,201	£550,611,45

In terms of human cost, approximately one in ten patients admitted to hospital suffered an unintended harm while being treated (Department of Health 2005). This figure has

remained consistent over the past ten years, while in other large industries fatal accidents and major injuries have been in decline since 2006 (The Health and Safety Executive 2010). This then raises the question of how the NHS can provide an appropriate level of care which can reduce the current volume of liability for failing to provide care at the appropriate level (Fenn et al.2004).

The legal databases of LexisNexis and WestLaw UK were used to search for Full Text court case transcripts on cases of clinical negligence including the healthcare team. Both databases provide the ability to perform a legal search on United Kingdom, European Union, and United States of America legislation, Case law, and of legal journals. Due to cases potentially being reported in a number of forums, - for example, court transcripts, Command papers, Independent investigations, and in a law journal article, - a comprehensive view can be obtained of the case.

The following tables (1-5) present the five groups selected for research; ‘Surgery’, ‘Obstetrics & Gynaecology’,’Medicine’,’Psychiatry & Mental Health’, and ‘Community Care’. One additional group (Group 6. ‘Other’) was developed to explore some of the wider issues within the legal cases.

Table 1. Group 1.

Group 1. Clinical Speciality; 'Surgery'
CASE 1. **Case reference.** *Chester v Afshar [2005] P.N.L.R. 14 UKHL 41 HL.* *Chester v Afshar [2005] P.I.Q.R. P12 [2004] UKHL 41 HL.* **Summary;** A female patient (Miss Chester) underwent an elective lumbar spinal procedure which resulted in serious neurological damage. The consultant surgeon negligently failed to give the claimant adequate warning of the dangers inherent in the surgery.
CASE 2 **Case reference.** *Rehman v University College London Hospitals NHS Trust. [2004] EWHC 1361.* *2004 WL 1174251.* **Summary;** Nursing & Medical staff discharged Ms Rehman following surgery with an undiagnosed perforated bowel
CASE 3 **Case reference.** *Goodson v H.M. Coroner for Bedfordshire and Luton Court of Appeal (Civil Division).* *[2005] WL 24933003.* *[2006} C.P. Rep 6.* **Summary;** Mr Harry Coleman (83) died following an elective procedure to deal with gallstones.

Table 2. Group 2.

Group 2. Clinical Speciality; 'Obstetrics & Gynaecology'
CASE 1. **Case reference.** *Michelle Anne Brindley v Queens Medical Centre University Hospital NHS Trust. [2005] EWHC 2647 (QB).* **Summary;** Michelle is Owen Bridleys' mother. Owen was born in 1999 with no kidney on the left side, a very small abnormal kidney on the right side, severe mental disability and deafness. Michelle claims the NHS Trust negligently failed to give her proper advice during the second trimester of her pregnancy. Involves the ultrasonographer, midwifery, consultant radiologists, and examines the decision making process.
CASE 2 **Case reference.** Ceri Ann Walters v North Glamorgan NHS Trust [2002] EWHC 321 **Summary;** Infant son died as a result of negligent treatment at the Prince Charles Hospital, Merthyr Tydfil. Claim of negligent diagnosis and prognosis.

Table 3. Group 3.

Group 3. Clinical Speciality; 'Medicine'
CASE 1 **Case reference.** *The Queen on the Application of Mohammed Farooq Khan v The Secretary of State for Health [2003] EWCA Civ 1129* *The Queen on the Application of Mohammed Farooq Khan v The Secretary of State for Health [2003] EWCA Civ 1129 [JUNE 2003]* *The Queen on the Application of Mohammed Farooq Khan v The Secretary of State for Health [2003] EWCA Civ 1129 [October 2003]* **Summary;** Naazish Khan was a three year old girl requiring haemodialysis to protect her from renal failure secondary to receiving chemotherapy. Naazish suffered a cardiac arrest and died suddenly from receiving a grossly excessive amount of potassium. These details were not disclosed on Naazish's death certificate. Mr Farooq Khan wanted to request an investigation under European law into the death of his daughter.
CASE 2 **Case reference.** *Gregg (FC) v Scott [2005] WL 62248.* **Summary;** Doctor misdiagnoses a lump under a patients arm as being benign when it is in actual fact malignant. This case raised a question which has divided courts throughout the common law world.

Table 4. Group 4.

Group 4. Clinical Speciality; 'Psychiatry & Mental Health'
CASE 1 **Case reference.** *Fairlie v Perth & Kinross Healthcare NHS Trust. [2004] WL 2295492. [2004] S.L.T.1200* **Summary;** Father seeking damages from the consultant psychiatrist after his daughter underwent Recovered Memory Therapy (RMT). The father averred that the consultant psychiatrist had failed in his duty to act with reasonable care to avoid foreseeable harm to him.

Table 5. Group 5.

Group 5. Clinical Speciality; 'Community Care'

CASE 1
Case reference.
Denise Lynn Merelie v Newcastle Primary Care Trust
Denise Lynn Merelie v Newcastle Primary Care Trust & Others.
[2006] WL 1732530 (QBH)
[2006] EWHC 1433.

Summary;
Denise Lynn Merelie was a dentist for principally school children and the elderly, but also for mentally ill or phobic patients. Four Dental nurses lodged a complaint the main allegation being that Denise was liable to outbursts of anger to staff and patients.
Two other dentists supported the allegations.

Table 6. Group 6.

Group 6. Clinical Speciality; 'Other'

CASE 1
Case reference.
R. (on the application of Rogers) v Swindon NHS Primary Care Trust and another.
[2006] WL 316105. QBD.
R. (on the application of Rogers) v Swindon NHS Primary Care NHS Trust and another.
[2006] 1 WLR 2649. COA.

Summary;
In June 2005, Ann Rogers tested positive for HER2 (type of breast cancer). Her consultant wrote to the Trust asking if it would pay for Herceptin, which was the new unlicensed treatment for cancer which was showing 'exciting results'. The Trust refused to pay for the treatment.
This case is similar to Barbara Clark where she was given Herceptin' and the ruling bypassed NICE, which raises questions about the role of Evidence in these situations and of course Rationing.

In total, ten legal ‘cases’ were analysed. This turned out to be a very rich research source, due to the high level of detail in the legal transcripts. Due to some of the cases going to a number of different court hearings, often there was more than one transcript

to analyse. When the analysis was completed some of the cases had overlapping themes, where they supported the findings, but did not add anything new. For this reason, the ten original cases were collapsed down to the following five cases for in-depth discussion and philosophical analysis.

Table 7. Final five cases selected for analysis.

CASE 1. **Case reference.** *Michelle Anne Brindley v Queens Medical Centre University Hospital NHS Trust. [2005] EWHC 2647 (QB).* **Summary;** Michelle is Owen Bridley's mother. Owen was born in 1999 with no kidney on the left side, a very small abnormal kidney on the right side, severe mental disability and deafness. Michelle claims the NHS Trust negligently failed to give her proper advice during the second trimester of her pregnancy.
CASE 2. **Case reference.** *R. (on the application of Rogers) v Swindon NHS Primary Care Trust and another. [2006] WL 316105. QBD.* **Summary;** In June 2005, Ann Rogers tested positive for HER2 (type of breast cancer). Her consultant wrote to the Trust asking if it would pay for Herceptin, which was the new unlicensed treatment for cancer which was showing 'exciting results'. The Trust refused to pay for the treatment.
CASE 3. **Case reference.** *Denise Lynn Merelie v Newcastle Primary Care Trust* *[2006] WL 1732530 (QBH)* **Summary;** Denise Lynn Merelie was a dentist for principally school children and the elderly, but also for mentally ill or phobic patients. Four Dental nurses lodged a complaint the main allegation being that Denise was liable to outbursts of anger to staff and patients. Two other dentists supported the allegations.

Table 7. Final five cases selected for analysis.

CASE 4. **Case reference.** *Goodson v H.M. Coroner for Bedfordshire and Luton Court of Appeal (Civil Division).* *[2005] WL 24933003.* *[2006} C.P. Rep 6.* **Summary;** Mr Harry Coleman (83) died following an elective procedure to deal with gallstones.
CASE 5. **Case reference.** *The Queen on the Application of Mohammed Farooq Khan v The Secretary of State for Health [2003] EWCA Civ 1129* **Summary;** Naazish Khan was a three year old girl requiring haemodialysis to protect her from renal failure secondary to receiving chemotherapy. Naazish suffered a cardiac arrest and died suddenly from receiving a grossly excessive amount of potassium. These details were not disclosed on Naazish's death certificate. Mr Farooq Khan wanted to request an investigation under European law into the death of his daughter.

The chosen cases cut across English and Scottish law, and they also represent the full judiciary system from High Court, Court of Appeal, House of Lords, and the European courts. The main feature in all of the cases is one of negligence, and for this the four elements of; Duty, Breach, Damage and Remoteness must be established (Tingle and McHale 2001). All of the legal cases examined fall into Jones definition regarding Duty of care;

> In cases of medical negligence the existence of a duty owed to the patient is usually regarded as axiomatic, and attention normally focuses on whether there has been a breach of duty or whether the breach caused damage (Jones 2003:12).

A number of the cases are interested in establishing if the medical and nursing staff also have a duty of care to the relatives, and to what extent this binds. Casen (2004) explains that when considering duty of care, it is the primary/secondary victim distinction which currently shapes the fate of claimants seeking damages for negligently inflicted mental trauma. The label of 'secondary' victim is generally reserved for those whose involvement with the incident is limited to witnessing or hearing of the imperilment of others.

Research Plan

The research approach is twofold. It involves a critical engagement with the literature and the utilisation of the empirical data, and secondly to develop a clear understanding of ethics in health care. This analysis will continue to be sensitive to the dynamic context of healthcare and will therefore continually review factors likely to influence

health systems in the future. An example of this would be the recommendation of Sir Derek Wanless (2002) who argued that the United Kingdom had fallen behind other countries in health outcomes, in part because the UK had spent less but also because it had not spent well. It concluded that the UK should devote a significantly larger share of its national income to health care over the following 20 years – reaching between 10.6 and 11.1 per cent of Gross Domestic Product (GDP) by 2022/3, up from 7.7 per cent in 2002/3. It will therefore be important to monitor the emerging philosophy of health systems as the recent Comprehensive Spending Review (CSR) states that targets and incentive systems to improve productivity should focus on health as the 'product'. The reimbursement system, Payment by Results (PbR), should play a part in encouraging a more automatic mechanism to encourage the NHS to seek out more productive ways of meeting patients' health care needs (Appelby 2007).

LEGAL ANALYSIS.

Introduction and Background

The empirical material of this study is composed of a literature review on a representative sample of Clinical negligence. Although different types of law will be discussed later, it is worth stating that while the law is divided into a number of specialist fields with each having its own language, procedures and substantive rules, the two principle categories of law are Civil and Criminal (Wall 2004). Within these two jurisdictions there is an overlap in that a criminal offence (for example assault) will often have an equivalent in the Civil jurisdiction (for example trespass). For the purposes of this study 'Case law' is being used, which comprises the corpus of decisions made by judges in either Civil or Criminal courts. This form of law has

evolved over time and is often referred to as ‘Common law’ or ‘Case law’. Such case-based reasoning takes a principle-based approach and is termed ‘Casuistry’. Toulmin defended and brought about a revival in the use of Casuistry in his book published in 1990; *The Abuse of Casuistry: A History of Moral Reasoning* (Toulmin & Jonsen 1990).

Due to this legal research representing the United Kingdom and its four constituent countries, relevant differences in the legal systems of England, Northern Ireland, Scotland, and Wales will be emphasised. While there are many differences at the micro level the four countries are similar to all others in the world in that their three major legal systems consist of civil law, common law, and religious law. This point is relevant as it is an admixture of these three which influences legal decisions, and appeals across countries for example from Scotland, through England to the European courts. It may seem *prima facie* impossible to attain any coherence and thereby rendering any comparative analysis of legal case transcripts invalid, but fortunately, all law is based upon two major systems, or a blend of the two, namely, civil law and common law. The historical background to the development of both should not be overlooked as they have fundamentally differing philosophical underpinnings which are relevant today as one jurist (Ronald Dworkin) has had a great influence in causing a paradigm shift within jurisprudence.

Civil law development comes from a history of autocratic government which has unlimited legislative and judicial power. It can be traced back to the Torah which contains the first five chapters of the Hebrew bible, and also to the ‘Corpus Juris Civilis’ from the Roman empire. The essence of this system is the way in which it is

autocratically developed, advertised to all citizens, the severe penalties imposed for breaching such laws, and the exceptionally strict conditions in which they were written out. The meticulous detail of the exactness in the unchanging manuscript can be seen today where scribes are unable to deviate from one dot ‘iota’ in writing out the Torah (Toulmin & Jonsen 1990). Such legal positivism will be crucial in any analysis of Case law in today’s post-modern context, especially in the light of Dworkin’s sophisticated philosophy of law as interpretation (Wacks 2006).

In Common law practice, judges have the authority to decide what the law is when there is no clear guiding statutory law. The process is that they must first follow any statutory law, or to have good reason for not doing this. Judges also refer to any previous similar cases and precedent therein contained. At the heart of common law is the concept of standing by court decisions (Mays 2001). Such ‘Precedent’ is binding on all courts of a similar or lower level. This can also be part of the process for developing statutory law, in that when a number of similar Precedents are codified into statutory law. It is crucial here to trace this process back to individual judges being the authors or legislators. Traditionally it was accepted that judges filled in the gaps left by rules of law by using their discretion (Freeman 2001). Hart (1997) thought that there were times when no matter how much judges scrutinized previous cases their application became indeterminate. This point is made explicit where he explains:

> In every legal system a large and important field is left open for the exercise of discretion by courts and other officials in rendering initially vague standards determinate, in resolving the uncertainties

> of statutes, or in developing and qualifying rules only broadly communicated by authorative precedents (Hart 1997: 136).

This situation is in contrast to that of the civil law as posited. In examining the two systems of law a range of fruitful questions arise related to the analysis of the selected case transcripts. Questions around the objectivity of jurists (Epstein 2007), the role of morality in such judgements, and the gap in the legal system between what 'is' and 'ought' to be.

Legal Research and Case Law

Legal research, in a similar fashion to any research, is the systematic process of identifying and retrieving information necessary to support legal decision making (Salter 2007). This study has used an iterative approach between primary and secondary legal authorities. The primary sources are composed of the verbatim texts of case law obtained principally through the electronic databases of 'Westlaw' and 'NexisLexis'. These are then cross referenced in books called Case Reports or Reporters. Secondary sources consist of legal opinion published in journals.

Since the court system is hierarchical a 'case' starts in the 'court of first instance' and can progress through appellate courts. Each time a case goes to court the proceedings are recorded verbatim and then published in Reporters and electronic databases. In a similar fashion to a research paper each case is published in a specific framework which provides information in a standard format on the Citation, Parties involved, Court, Hearing dates, Summary, Legislation and previous cases referred to, and the

Decision (Thomas 2006). In this way a case remains live until the time for granting a re-hearing has passed (Elias & Levinkind 2005).

Within each case the *Ratio decidendi* (the reason for the decision) is explained in detail with numerous citations to previous decisions and other legal authority (Woodley 2005). Via this process we can see how Dworkin challenges legal positivism and instead argues that a judge does not make law but instead interprets what is already part of the legal materials (Dworkin 1998). The authors of Autopoietic theory go further by proposing that the legal system is similar to the typical biological system which is self-replicating, and where the initial properties of a member of one generation are controlled by properties of members of the preceding generation (Teubner 1993). Autopoietic theory was originally developed by Maturana and Varela (1991) to explore the individual organism and to explain the particular nature of *living* as opposed to *non – living* entities. Niklas Luhmann (1995) developed the theory to make autopoiesis the basis of his social theory. When this theory has been applied to the legal system it assists in understanding the independence and autonomy, - or the degree of closure - , in the legal system[24]. Further, it helps to distinguish from collective and individualised regulation where the two may co-exist, but where they are analytically distinct and therefore raise significantly different notions of justice.

This is a pertinent theory as jurists also change what was previously background text in previous citations (*Obiter dictum)* into a binding precedent in the form of *Ratio decidendi*. In this way the law is said to be operationally closed. Both approaches will

[24] Closure is defined as where all legal procedures always reproduce the system.

be useful in analysing the legal transcripts for the degree to which law is autonomous or socially conditioned.

Research Methodology

While the overall research method of the thesis is one informed by critical analysis, some specific questions have to be addressed in analysing decisions in reported judgements. One of the most fundamental questions is regarding the most valid approach to interpreting the legal documents, and this aspect is crucial due to the divide within law as a discipline where there are pure 'doctrinalists' and those who take an interdisciplinary approach. Vick highlights this where he states;

> Legal researchers have to take into account the intellectual tension, and discernible friction between black letter academic lawyers using traditional modes of legal analysis and those who would classify themselves as Interdisciplinary scholars using ideas and techniques borrowed from other disciplines (Vick 2004 :163).

The significance of this point is that it is the 'doctrinalists' who define what law is and what sits within this definition. At the professional and academic levels they control what is deemed as legal knowledge, even to the point of who can register as a practising lawyer, and what books on law can or cannot be published. Precisely due to this tension within the discipline of law, issues surrounding validity of methodology need to be discussed and made explicit to address the criticisms which can be anticipated from within this 'academic tension'. Hutter and Lloyd-Bostock (1997) go as far to suggest there is no possibility of conducting legal research other than through the

application of a particular frame of reference which determines how the dissertation is created, formulated and pursued. Questions of validity also need to address the fact that legal facts are open to interpretation as outlined by Salter and Manson:

> In other words, the same points of law and fact that have been interpreted in a certain way by one side to a legal dispute are frequently susceptible to diametrically opposite interpretations of no lesser plausibility by lawyers representing the other party (Salter and Manson 2007: 41).

Primary legal sources which include cases and statutes are not in themselves inherently black letter materials but it is this approach which is used at the exclusion of other approaches such as socio-legal in 'Case law'. The legal analysis will therefore take a two stage approach. First the primary legal sources will be analysed using the black letter approach, then these findings can be subjected to a critical analysis. To commence with an interdisciplinary approach such as socio-legal would unnecessarily expose the study to criticisms of not understanding the process of law development, interpretation, and decision making.

Black-letter Approach

The black-letter approach provides an exact method for understanding law as a practised system and a recognised legal framework for interpreting Case law. Balkan describes the black-letter approach as '…through the lens of a specific interpretative framework' (Balkan 1996: 956). This framework involves seeing each case as if it formed part of a system of rules which are internally connected and related to each other in distinct clusters and groups (Hofheinz 1997). Such rules are imbedded in other

'Cases' and in Statutes with the internal connections being identified through cross-referencing specific rules, and through the identification of legal principles and axioms. A philosophically significant point is that within this approach the analysis must 'insulate' the topic from supposedly 'non-legal factors' which would include policy, political, social and economic issues as though these were somehow 'external' to legal research (Hofheinz 1997).

Whilst the criteria for selecting 'Cases' has been previously identified it is now necessary to outline how the many hearings within a case are prioritised. This is performed by paying particular attention to the most recent appeal judgements regarding the case in, for example, the Court of Appeal, House of Lords, and the European Court of Justice. Twining (1994) helpfully explains that disputed points of law largely dominate the lower level courts, and that points of law prioritised by the black-letter tradition are mainly found in superior courts. Within legal reasoning 'Cases' are located at the base of a hierarchical pyramid with legal rules, legal principles and axioms being prioritised above this.

Law of Negligence

Case law covers both civil and criminal jurisdictions. The specific aspect of law which is being examined in the legal transcripts is Negligence. The law of negligence is expressed in Tort in common law systems and Delict in the civil law system (McLean & Mason 2003). Although there are seven different categories of Tort law, Negligence is the dominant tort.

‘Clinical negligence’ is any litigation involving negligence in the delivery of healthcare (Wall 2004). In tort law clinical negligence has the effect of imposing costs on interested parties. It has been suggested that court judgements in the tort law of negligence have the effect of promoting cost effectiveness in the provision of health care (Heasell 2004). Others have argued for economic theories which have sought to establish a broadly utilitarian theory for the attribution of liability (Merry 2002; 152). The aim of such claims is to address issues of unsatisfactory quality of care. This legal system is linked to the NHS governance framework which is answerable to claims of negligence and puts the Chief Executive as having overall accountability, and responsibility to influence clinicians, allocate resources with the underlying risk, rights and responsibilities. Such a system however may contribute to ‘defensive medicine’ where doctors carry out investigations that may not be necessary just to insure against every eventuality. Some develop this argument further in outlining the regulatory overload imposed upon the NHS, the consequent impaired capacity to manage effectively, and most poignantly; the development of a defensive compliance (Scrivens 1995, Walshe 2003a, 2003b).

Negligence in law is founded upon one of the most famous cases in British legal history; *Donoghue v. Stevenson.* ([1932] A.C. 532, 1932 S.C. (H.L.) 31, [1932] All ER Rep 1) (Wall 2004). This case will be discussed in more detail in a later chapter.

Patient Expectations in litigation

Litigants take their accusations of negligence to court with the expectation that some understanding may be gained of what happened, for some legal redress where the court

will adjudicate in the matter (in the same way as would any fair-minded individual independently of the legal context), and also to be compensated for any distress caused. From this position litigants view the legal system as imbued with moral values. In reviewing the ten selected cases of clinical negligence a number of philosophical questions are presented for analysis;

1. What connections and overlaps are there between morality and the law?
2. To what extent do judges exercise discretion when there is a 'gap' in the law?
3. Is there an 'internal morality' in rule making?

Morality and Law

Contemporary clinical issues which are taken to court are explored via the black letter approach. In the cases reviewed this has resulted in an approach which excludes everything but a purely legal view of the case. This point can be seen in all of the cases but most poignantly in Goodson ([2004] EWHC 2931) where the coroner recorded a verdict of 'death by misadventure' and the daughter wanted to appeal against the coroners refusal for the inquest into the death to be carried out as an investigation for the purposes of article 2 of the European Convention on Human Rights (The obligation to protect the right to life). From the clinical information it is clear to see that Mr Coleman had suffered a perforated duodenum when the consultant surgeon had carried out an Endoscopic Retrograde Cholangio-Pancreatography (ERCP) sphincterotomy and stone extraction. Mr Coleman's' clinical notes documents his deteriorating condition to a point where a decision is made to treat him conservatively (withhold treatment), with

a resultant cardiac arrest. Given the significance of the clinical details in adding weight to a legal argument this point is worthy of further analysis. In his judgement Richards stated;

> In relation to each basis it is submitted that the coroner, who is not medically qualified, was wrong to refuse to seek independent medical evidence in reliance solely upon his own uninformed view that there was no ground for considering that the medical personnel involved might have been negligent and that he trusted them to give an objective opinion on their area of expertise as to the adequacy of their own treatment which lead to Mr Colemans' death (Goodson ([2004] EWHC 2931: Para. 29).

It may be considered from what was stated that the clinical evidence then should be reviewed and a differing judgement made, but it was not reviewed, and the appeal was dismissed.

Issues which are excluded at the beginning of a case are difficult to reintroduce at a later date. This legal principle was set out in Whitehouse v Jordan ([1981]1 WLR 246 at 249F) where Lord Wilberforce said there are strict limitations on the power of an appeal court to reverse the decision of a judge on an issue of fact, and Lord Wilberforce went on to explain;

> The main reason why, in the absence of an error of law, the judgment of the trial judge calls for the utmost respect is that he has seen and heard the witnesses ....The strength of this consideration will vary from case to case according as conclusions have been reached as to credibility, or based on demeanor (Whitehouse v Jordan ([1981]1 WLR 246 at 249F: page 636).

There are a number of cases which have set this precedent including Maynard v West Midlands Regional Health Authority ([1984] 1 WLR 634) where in the House of Lords, Lord Scarman said 'In English law the appeal process is a rehearing of fact and law. But the limitations upon an appellate Court's ability to review findings of fact are severe and well-established'.

The black-letter approach does not ignore or exclude moral issues; rather they are subordinated to law. In Fairlie v Perth and Kinross Healthcare NHS Trust ([2004] S.L.T. 1200) -where a father sought damages for negligence when a consultant psychiatrist treated his daughter with recovery memory therapy (RMT) and as part of this therapy she falsely alleged that her father had sexually abused her-the emotional issues are addressed but the legal process clarifies the case as one which should have been presented as a claim for 'defamation'. Lord Kingarth explained:

> Had the claim been made as a claim for defamation, questions would have arisen in relation to the defense of qualified privilege and in relation to time bar. It would be wrong to allow the pursuer to advance a claim for defamation in the guise of a claim for damages based on negligent statements (Fairlie v Perth and Kinross Healthcare NHS Trust ([2004] S.L.T. 1200: Para. 13).

The emotional and moral issues of the father being wrongly accused of sexually abusing his daughter were further clarified through defining to whom the duty of care was owed, i.e. the daughter was the patient. By following the legal process of examining similar cases, applying legal precedent, and using legal tests to define negligence (Hunter v Hanley 1953 S.L.T. 62, Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634 and Bolitho v City and Hackney Health Authority [1998] AC 232)

it was agreed that the duty of the therapist is to the patient, the criticism of the consultants standard of care was identified as problematic where Lord Kingarth states

> Turning to the second (regarding standard of care) of the defenders' broad criticisms of the pursuer's pleadings, I am less impressed with these. It seems to me reasonably clear that on a consideration of the pleadings as a whole the pursuer is offering to prove that Dr Yelowlees fell below the standard of a reasonably competent professional (Fairlie v Perth and Kinross Healthcare NHS Trust ([2004] S.L.T. 1200: Para.33).

This point was undecided because the case had been presented essentially as a claim for defamation in the guise of a claim for damages for losses caused by negligence. The moral issues within such a judgement can be seen in the judges' final comments;

> In all these circumstances I am persuaded that the first and third broad heads of argument advanced by the defenders are sound and that the action falls to be dismissed, as a matter of law. I stress "as a matter of law" because it goes without saying that if, as the pursuer claims, Dr Yellowlees made the diagnosis which it is said he did, and it was one reached carelessly without proper investigation, the pursuer's concern to seek redress is wholly understandable. I am nevertheless required to decide this case within the boundaries of the law as it has recently developed (Fairlie v Perth and Kinross Healthcare NHS Trust ([2004] S.L.T. 1200; Para. 38).

Some may argue that morality enters the legal system through statute law rather than Case law.

PHILOSOPHICAL ANALYSIS; Existential phenomenology/Hermeneutics.

The foregoing section on 'Legal Analysis' has highlighted the reductive perspective imposed by the Black-letter approach to investigating alleged cases of clinical negligence. It was also established that non-legal factors are isolated in the legal analysis in two main ways: the first is through the hierarchical structure of the court system, so that really only the judge in the court of first hearing has the privilege to see the claimant and defendant face-to-face. The second mechanism for isolating non-legal factors is through the bracketing process of the Black-letter analysis.

The purpose of detailing the legal analysis was to trace the clinical problem through the legal process, to its ultimate conclusion in law. The problem that was identified was that the ethical/moral dimension of the clinical problem is separated out during the legal interpretation of negligence. This is why it appears potentially valuable to set up a contrasting dialogue between the legal and a philosophical analysis of the same legal transcripts.

This section on Philosophical analysis aims to outline the method used to explore the legal transcripts from a philosophical perspective. It will commence by outlining the development of phenomenology (Edmund Husserl), through hermeneutic phenomenology (Martin Heidegger and Hans-Georg Gadamer), to an *Expanded* existential phenomenology as found in the works of Levinas.

Once the foundations are established for the expanded existential phenomenology, the latter part of this section will provide the detail on how this theory was applied to the

legal transcripts in the philosophical analysis. In order to achieve these aims this discussion will be divided into the following parts;

- The development of phenomenology-Husserl,
- The development of phenomenology-Heidegger,
- The development of phenomenology-Levinas,
- Detail of the philosophical analysis,
- Conclusion.

THE DEVELOPMENT OF PHENOMENOLOGY-HUSSERL.

Phenomenology is a philosophical movement that has had its greatest development in Husserl (Solomon 2001). It is both a disciplinary field within philosophy, and also a movement in the history of philosophy. While Edmund Husserl is often cited as the founding father of phenomenology, the concept can be traced back to Aristotle, and the term was certainly used in the title of Hegel's book; *Phenomenology of Spirit,* which was first published in 1807. Husserl synthesised what was previously the two different areas of research, in psychological theory (Franz Brentano, William James) and the theory of logic (Bernard Bolzano, Gerhart Husserl[25] and Gottlob Frege) (Smith 2011). Husserl challenged the dominant views on the nature of truth at the time. For example he criticised psychological theory for trying to apply methods from the natural sciences to explore human issues (Laverty 2003).

[25] Son of Edmund Husserl.

The phenomenology of Husserl inaugurated a new approach within philosophy when he designated consciousness as the departure point for phenomenology (Giorgi 2005). For Husserl, the structure of consciousness was based upon Brentano's work on *intentionality* which proposed that only mental states are intentional (Crane 1995). Husserl was interested in the epistemology of this problem, so his conceptual framework focused on conscious awareness as the foundation to building knowledge of reality. Phenomenology then for Husserl is the study of lived experience which he termed *Erlebnis* (van Manen 1997). This life-world is taken as what we experience pre-reflectively, without applying concepts, and frequently includes what is taken for granted (Husserl 1999). In this way Husserl viewed consciousness as constituting the life-world of the individual, and also of the individual constituting the world.

In reviewing nine key thinkers in phenomenology, Moran (2000) explains that the concept of the phenomenological reduction is a key epistemological strategy. According to Moran, the reduction was proposed by Husserl, then developed by Heidegger, reinvented by Merleau-Ponty, and then applied by Levinas, but with an ethical emphasis (Moran 2000). There appears to be an important distinction in the focus of each of these philosophers work with Husserl primarily upon epistemology, Heidegger on ontology, and more recently, with Levinas developing a phenomenology of sense within ethics.

The use of phenomenological reduction or bracketing is crucial to this thesis as it will be proposed later as a feature within legal analysis where 'non-legal factors' are isolated from the analysis stage. When the legal process is considered as a research

method, the participants of the study are interviewed, this is digitally recorded and transcribed, but it is only when all of the facts of the case have been heard that non-legal issues are bracketed. While Husserl proposed the phenomenological reduction-suspending particular beliefs about the phenomena, and identifying presuppositions-in order to see things 'as they are', the bracketing in legal analysis is done specifically to see things *as they are in law*. While it removes a certain bias, it also provides a systematic-and planned- bias.

THE DEVELOPMENT OF PHENOMENOLOGY-HEIDEGGER. .

Heidegger differed from Husserl in how the lived experience is explored. Instead, he proposed that hermeneutics -as founded upon the ontological view-should be used as a research method in exploring the lived experience of individuals. It is significant for this thesis that Heidegger was influenced by Kierkegaard, and thereby was one of the first thinkers to combine existentialism with phenomenological methodology (Yagi ND). This then provides a conceptual framework which supports phenomenology, hermeneutic phenomenology and existentialism. Todres and Wheeler support the philosophical coherence of phenomenology, hermeneutics, and existentialism as a philosophical perspective for nursing research (Todres and Wheeler 2001).

Heidegger focused on the situated meaning of a human in the world. He called this *Dasein.* He also viewed humans as being concerned about their fate in an alien world (Inwood 1997). Heidegger also emphasised the dynamic of an individual's background, which includes what a culture hands down to a person. He termed this *historicality.*

This feature will be contrasted in the body of the thesis in relation to the existential theme of freedom.

The movement within phenomenology from Husserl's epistemology, through Heidegger's ontology, to include Kierkegaard's existentialism can be seen where Yagi proposes;

> Kierkegaard's self and Heidegger's *Dasein* therefore mark the reversal of the ontological priority in that it is not the foundation of our knowledge (validity of knowledge) to which we must look, but the manner in which we as unique individuals engage in and delve into an activity such as a quest for knowledge. Hence they incorporate in their pursuit of knowledge the preoccupation of understanding ourselves, our way of Being. In turning away from the strictly theoretical approach to philosophy, Kierkegaard and Heidegger converge in a number of defining moments which bring to light a radicalised conception of existence. (Yagi ND; 63)

This 'reversal of the ontological priority' will be discussed in Chapter 4 in relation to virtue ethics, and hermeneutics will be discussed in chapter 5 in relation to the legal transcripts. However, in the philosophical analysis hermeneutics has an expanded interpretation to apply not only to texts, but also to people. Hermeneutics then becomes a method for interpreting people (patients in this case).

So far in the historical development of phenomenology, *intentionality* has been foundational, even if the emphasis has changed from epistemological, to ontology; '…the manner in which we as unique individuals *engage*[26]…(Yagi ND; 63)'.

[26] Emphasis added.

Hans-Georg Gadamer extended Heidegger's work on hermeneutic phenomenology. He also seems to highlight this problem regarding intentionality-in the sense of understanding an individual (patient), when explains;

> Hermeneutics must start from the position that a person seeking to understand something has a *bond*[27] to the subject matter that comes into language through the traditionary text and has, or acquires, a *connection*[28] with the tradition from which it speaks (Gadamer 2004;295).

When considering hermeneutic phenomenology in relation to understanding individuals, the aspect of theory which appears to be neglected is exactly how we engage, develop a bond, or acquire a connection with the other. The following section will propose Levinas' expanded existential phenomenology as a foundation for the bond with the other.

THE DEVELOPMENT OF PHENOMENOLOGY-LEVINAS.

Levinas is not usually considered an existentialist as such (Please see Appendix 5. Genealogy of existentialism.). Strikingly, some of his writings such as *On Escape* (Levinas 2003), *Existence and Existents* (Levinas 2008[a]), and *Totality and Infinity* (Levinas 2008[b]) do contain lengthy discussions on existentialism.

Levinas sets out his phenomenology in *Totality and Infinity* (Levinas 2008[b]) where he sets out the structure of relation with the other; 'The way in which the other presents

[27] Emphasis added.
[28] Emphasis added.

himself, exceeding *the idea of the other in me,* we here name face (Levinas 2008[b]; 50)'.Where Husserl sought to limit sense, Levinas expands the horizons of phenomenology in the concept of *face.* In a similar fashion Levinas's perspective overthrows Husserl's historicity;

> The face of the Other at each moment destroys and overflows the plastic image it leaves me, the idea existing to my own measure and to the measure of its *ideatum*-the adequate idea(Levinas 2008[b];51).

Writing in *Entre Nous* Levinas explains the principle *trope* in his later phenomenology as the unpresentable *trace*[29]*:*

> I have attempted a 'phenomenology' of sociality, taking as my point of departure the face of the other, proximity, by hearing-before all mimicry, in its facial straightforwardness, before all verbal expression, in its mortality, from the depths of that weakness-a voice that commands: an order addressed to me, not to remain indifferent to that death, not to let the other die alone; that is, an order to answer for the life of the other man, at the risk of becoming an accomplice to that death (Levinas 2006a:146).

This concept provides an ethics of ethics, or theory of ethics, which applies to the individual, society, and Levinas also works this out at the political level. For Levinas, this responsibility for the other precedes consent, every contract, and it precedes

[29] Trope is from the Greek *tropos* meaning 'turn' or 'turn of speech' (Mautner 1999; 573). It is '…a kind of figurative, non-literal, use of words which achieves its effect by deviating from the standard meaning of the words used (Mautner 1999;573)'

ontology '…I am obliged without this obligation having begun in me, as though the order slipped into my consciousness like a thief, smuggled itself in…'(Levinas 2008a;13). Such a position will be seen later to be in contrast to Kant, as this responsibility is prior to the thematizing of consciousness, and is not an obligation based upon the universalization of maxims. Similarly, Kierkegaard has a concern at the heart of his philosophy for an authentic way of existence which is free from the crowd, and free from being defined by their context. Kierkegaard explains;

> Now, all in all, there are two ways for an existing individual: either he can do everything to forget that he is an existing individual and thereby manage to become comic (the comic contradiction of wanting to be what one is not, for example, that a human being wants to be a bird is no more comic than the contradiction of not wanting to be what one is, as *in casu* [in this case] an existing individual, just as in the use of language it is comic when someone forgets his name, which signifies not so much forgetting his name as the singularity of his nature), because existence possesses the remarkable quality that an exiting person exists whether he wants to or not; or he can direct all his attention to his existing (Kierkegaard 1992a:120).

The detail of this authentic existence is provided within the thesis where the *aesthetic*, *ethical* and *religious* stages are discussed as part of the theoretical analysis, along with Kierkegaard's concepts of *irony* and *repetition*.

One of the problems highlighted in this section regards intentionality. Drabinsky believes that '…the problem of intentionality as such is the problem of relation

(Drabinsky 2001; 17)'. Levinas and Kierkegaard however, provide the structure for this relation in the concept of *face*, and subjectivity is the relation.

The philosophical analysis is based upon this expanded existential phenomenology. As such Drabinsky states;

> A phenomenology aimed at describing this pre-predicative life (with all qualification due regarding the term "description") opens up the possibility of another *practice* of phenomenology. That is, the exploration of the relational structures of pre-predicative life explores the limits imposed by the idealist's closed system of predelinated horizons (Drabinsky 2001; 20).

It is then, this pre-predicative life that the analysis aims to uncover in the legal transcripts. Below the procedure for performing the analysis is explained.

Detail of the philosophical analysis.

Once the legal transcripts were downloaded as pdf. (Portable Document Format) files from the electronic law databases (Westlaw and NexisLexis); they were then printed out onto A4 paper. Following this they were then photocopied onto A3 size paper. Such a format allows the text from the transcripts to take up the right hand of the A3 page, and leaves the left hand of the page for taking notes and identifying existential themes in the transcripts of alleged clinical negligence.

The main existential themes will be critically analysed within the body of the discursive chapters 4-8. However, the main discussion is based upon the following identified themes in the work of Kierkegaard, Sartre, and Levinas;

- Freedom,
- Personal responsibility,
- Authenticity/Anxiety/Passion-engagement,
- Situatedness/Facticity,
- The crowd/political dimension,
- Subjectivity as truth.

Conclusion

This chapter has provided the rationale for performing two literature reviews. The first on published research within healthcare journals on ethics and whistleblowing. This was performed to establish the current thinking on these topics, and in order for the findings to inform the second literature review which was on the legal transcripts. The legal transcripts were subjected to two levels of analysis, first the legal and analysis, and then the philosophical analysis.

Existential phenomenology was outlined as developing from Husserl, through Heidegger, and Levinas's expanded existential phenomenology was presented as the favoured method to critically analyse the legal transcripts.

The next chapter will commence with the first literature review on ethics and whistleblowing.

CHAPTER THREE: 'EVIDENCE' IN ETHICAL DECISION MAKING.

> But in knowledge there also appears the notion of an intellectual activity or of a reasoning will-a way of doing something which consists precisely of thinking through knowing, of seizing something and making it one's own, or reducing to presence and representing the difference of being, an activity which *appropriates* and *grasps* the otherness of the own (Levinas 2009b: 76).

Introduction

The work of Levinas-as exemplified above- has thrown up a question about the role of 'evidence' in providing ethical care to a patient. Within health care Evidence-Based Practice (EBP) is a powerful philosophy which holds that all care should be based upon evidence. To facilitate this process there are many structures in place to provide evidence. Unfortunately, EBP has been heavily criticized since its inception.

The problem which emerges for the current study is that most research projects would carry out a literature review as foundational for the study. However, Levinas is suggesting that the ethical relation is *prior* to concepts and *prior* to Husserl's intentionality. From this arises the challenge of constructing an argument using the dominant narrative-empirical research-on a topic which is anterior to epistemology. That is, for Levinas, the relation with the patient (Other) cannot be reduced to perception, where applying concepts to the other person can have a limiting dynamic.

As a consequence of this challenge, this chapter aims to discuss the role of 'evidence' in ethical decision making, *prior* to commencing the literature reviews in the next chapter.

Evidence Based Medicine (EBM) was pioneered by the British epidemiologist, Archie Cochrane (UK Cochrane Centre 2013). Cochrane was a prisoner of war for four years where he had the role of senior medical officer for 20,000 prisoners of war (POW) (Cochrane 1999). This experience of caring for POW, who suffered from poor nutrition, typhoid, diphtheria, and tuberculosis, seems noteworthy as very few died in these squalid conditions despite the lack of medical resources (Cochrane 1999). In evaluating the role of evidence-especially Randomised Controlled Trials (RCTs)-it is poignant to highlight the care Cochrane provided to a Soviet prisoner. In his autobiography Cochrane explains that he was given a Soviet prisoner to care for who was suffering from a severe pleural rub (Cochrane & Blythe 2009; 82). Being unable to speak any Russian, and with no Morphine to relive the severe pain, Cochrane took the screaming prisoner in his arms. Cochrane reports that the prisoner stopped screaming almost at once, and died some hours later in his arms (Cochrane & Blythe 2009; 82).The significant point being, that it was not the pleurisy which was causing the pain, but loneliness (Cochrane & Blythe 2009; 82).

This section is going to explore the development of EBM and the critical point of these differing types of ‘evidence’ as portrayed in Cochrane’s actions towards the prisoner. That is, it is proposed that a RCT could readily be found on a respiratory problem such as a pleural rub. In contrast, it would be challenging to find a RCT on existential loneliness as experienced by a Russian prisoner of war.

Background and development of EBM/EBP.

The philosophy of EBM developed out of concern that many patients/clients were receiving clinical interventions which were based upon convention, intuition, and that such an approach was ineffective (Sacket et al 1996). EBM was also part of Clinical Governance through which the NHS was continuously improving the quality of the services provided to patients while at the same time operating within fiscal constraints (Scally & Donaldson 1998). A relevant aspect of Clinical Governance is that it aims to enforce compliance with nationally devised evidence based policies (Onion 2000). It achieves this through clinical guidelines and national service frameworks (McSherry & Pearce 2011).To establish clear guidance on best practice, a National Institute of Clinical Excellence (NICE) was created to give new coherence and prominence to information about clinical and cost effectiveness (McSherry & Pearce 2011). Through this process the British government has endorsed EBM as being both clinically, and cost effective in that with limited resources money will be best spent on interventions with proven effectiveness and efficacy (Department of Health 2010).

Cochrane's work was developed through Canadian researchers working at McMaster University which was led by David Sackett and Gordon Guyatt (Sur & Dahm 2011). Sacket et al. (1996) define evidence based medicine as;

> …the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By

> individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice (Sacket et al. 1996; 71).

It is the *judicious use of* and *integrating individual clinical expertise* that will be the focus of argument in the following sections.

Evidence-based practice (EBP) evolved from EBM and spread to other professions such as nursing, physiotherapy, psychology, education, and dentistry (Aveyard & Sharp 2013). EBP is an interdisciplinary approach to clinical practice where health professionals base their care upon the same national guidelines such as those produced by NICE, the Cochrane database, or SIGN (Scottish Intercollegiate Guidelines Network) for the NHS in Scotland.

Philosophical foundations of EBP.

Evidence-based practice[30] makes a number of epistemological assumptions. These conflicting and incoherent assumptions favor one particular form of 'reliable' evidence over other forms of evidence, and also harbor a misguided understanding of the knower. Each of these assumptions will be considered in turn, in relation to the potential harmful affect they have upon delivering a high standard of care to individual patients.

Philosophy consists of five branches. These are Metaphysics (Study of existence), Epistemology (Study of knowledge), Ethics (Study of action), Politics (Study of force) and Aesthetics (Study of art). There is a hierarchical relationship between these

[30] Also sometimes referred to as Evidence-Based Healthcare Practice (EBHP).

branches. At the root is metaphysics, which is closely related to epistemology. Ethics is said to be dependent on epistemology because it is impossible to make choices without knowledge. Politics is a subset of ethics. Aesthetics is dependent upon metaphysics, epistemology, and ethics[31].

Epistemology-which is also called the theory of knowledge-, is the branch of philosophy concerned with enquiry into the nature, sources and validity of knowledge (Grayling 2003; 37). Since the primary question of epistemology considers what is knowledge, '…the standard preliminary definition states that knowledge is *justified true belief*[32](Grayling 2003; 37). Therefore, what we know is a subcategory of what we believe.

Within contemporary analytical philosophy there are two schools of thought about justification; Evidentialism (Conee & Feldman 2004) and Reliabilism (Goldman 2011, 2012). Evidentialism claims that evidence provides justification for beliefs (Conee & Feldman 2004). 'Evidence' means the contents of direct experiences mediated by perception, memory, intuition or introspection (Conee & Feldman 2004). Conee and Feldman explain that Evidentialism is a version of epistemic internalism, and that recent epistemology has included many attacks on internalism and has in turn seen the development of numerous externalist theories (Conee & Feldman 2004). Reliabilism is in contrast, a version of epistemic externalism. That is, for reliabilists, the source of

[31] The purpose of setting out this overview is to assist the later discussion which will explore different ways of knowing. Some of which will consider the relationship between ethics and epistemology. In later chapters consideration will be given to Levinas' proposal that ethics is first philosophy.
[32] Emphasis in the original.

justification for knowledge is external, because a belief is justified *only if it has been formed as the result of a generally reliable process*[33] (Goldman 2012). Hutchison and Rogers incisively distinguish between evidentialism and reliabilism by stating,

> …reliabilists claim that justification derives from sourcing beliefs through reliable methods; these might include perception or memory, but the key point is that it is the *process*[34] from which the evidence derives, rather than the evidence itself, which justifies the belief (Hutchison & Rogers 2012;986).

Evidence Based Practice- with its *process* for performing Systematic reviews and Randomized Controlled Trials (RCTs)-then seems to be within the reliabilist school of justification[35]. In addition to these stipulated methods of research, one of the most crucial aspects of EBP is its emphasis upon the epistemic hierarchy for 'evidence' (Figure x). It can be seen from Figure x. that priority is given to RCTs, systematic reviews, and meta-analyses. All of these methods derive their recommendations on modal information from populations or subgroups (Hasnain-Wynia 2006; 2). As a research method, the gold standard approach-RCTs- standardizes, rather than individualizes, patient care (Hasnain-Wynia 2006; 1 Thompson 2002; 2). It can also be seen that the hierarchy of evidence places 'expert opinion' (internally mediated evidence-Evidentialism) at the bottom of the hierarchy. Significantly, this is an inversion of how the pyramid would have been prior to EBP, when the individual experience of health professionals would be the main source for informing decision

[33] Emphasis added.
[34] Emphasis in the original.
[35] Schwab argues that Reliabilism is an attractive epistemic perspective for medical practice (Schwab 2008).

making (Bartolucci et al. 2010). Such a prioritizing of evidence has consequences for the individual patient as health professionals attempt to integrate the two epistemic approaches [reliabilism and evidentialism] to justifying belief.

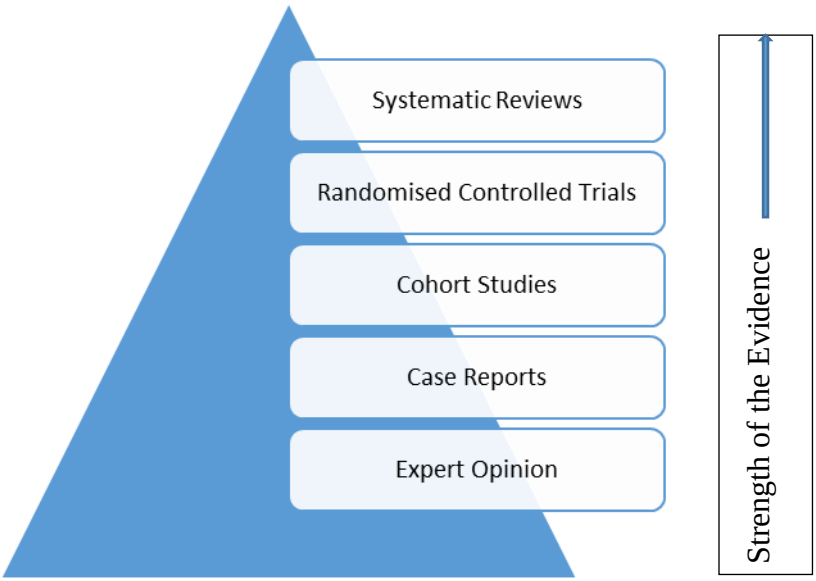


Figure 5. Hierarchy of Evidence Based Practice. Developed from Phillips et al. (2009), Evidence Based Nursing Practice (nd), and Sackett et al. (2000).

EBP as a new paradigm?

In 1992, a working group consisting of thirty clinical scientists and clinical teachers co-authored an article where evidence-based medicine was described as a shift in medical paradigms (Guyatt et al.1992). The move was from the traditional paradigm of medical practice, to EBM which proposes that intuition, unsystematic clinical experience, and pathophysiological rationale are insufficient grounds for clinical decision making

(Guyatt & Busse 2006). Instead, EBM places emphasis upon the examination of evidence from clinical research (Guyatt & Busse 2006).

At this stage in the discussion the work of Carper is helpful in providing a framework to highlight this ‘paradigm’ shift in sources of evidence (Carper 1978). In her typology of nursing epistemology, Carper proposed that there are ways of knowing which are not scientific, and perhaps not empirical (Porter 2010). Carper distinguished between ‘empirics’ (scientific knowledge), on the one hand, and ‘aesthetic’ (art), ‘personal’ (required for authentic personal relationships), and ‘moral’ (Carper 1978) (Please see figure 6 below).

	SCIENTIFIC	NON-SCIENTIFIC			
EBM[36] SACKETT ET AL. (2000).	Best Research Evidence		Clinical Expertise		Patient Values
KUHN (1962).		TACIT KNOWLEDGE……			
POLANYI (1962).		TACIT KNOWLEDGE……			
CARPER (1978).	Empirical	Aesthetic	Personal	Moral	
BENNER (1984).	Know what	Know how	Intuition		
MUNHALL (1993).					Unknowing
WHITE (1995).					Socio-political
FAWCETT ET AL. (2001; 118).		Aesthetic theories	Personal theories	Ethical theories	
RYCROFT-MALONE ET AL. (2004).		Professional craft knowledge & reasoning			

Figure 6. Sources of 'evidence'.

[36] Cochrane's classic text 'Effectiveness and efficiency: random reflections on health services' had a profound influence on the practice of medicine and on the evaluation of medical interventions. He was the first to set out clearly the vital importance of RCTs for assessing the effectiveness of treatments (Cochrane 1972, Claridge and Fabian (2005; 552)).

Subsequent authors have added other ways of knowing, such as ‘intuition’ (Benner 1984), ‘unknowing’ (Munhall 1993), ‘socio-political knowing’ (White 1995), and ‘craft knowledge’ (Rycroft-Malone et al. 2004). Similar frameworks to Carper’s can be found in physiotherapy in the ‘propositional’, ‘professional’, ‘craft’, and ‘personal knowledge’ as recommended by Higgs and Titchen (1995). For the current discussion, the distinction between empirical and tacit knowledge will be sufficient.

EBP – Assumption; Empirical research as the only ‘evidence’.

Since its inception, EBP has been criticized for its narrow focus upon empirical evidence, while not considering the patients perspective, and for denigrating the role of clinical expertise (Cohen et al. 2004). In order to defend EBP, Sackett et al. responded that EBP

> …requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients’ choice, it cannot result in slavish cookbook approaches to individual patient care (Sackett et al. 1996: 72).

As a result the debate has produced research on the topics of including patients in decision-making, patient-focused care, and in considering patient values. This section aims to highlight the role of tacit knowledge, and thereby the ineliminable and irreducible role of the individual health professional in integrating the tripartite division of; best research evidence with clinical expertise and patient values.

EBP has attained the status of a law (Samanta et al 2006). As such, litigation is a powerful tool for influencing clinical practice as health professionals observe the consequences of following, or not following clinical guidelines. For example, solicitors and barristers use clinical guidelines in litigation, and increasingly so as part of trial strategy (Samanta et al. 2006) Such an approach is deeply problematic as when considering what should happen when there is no clinical guideline. Grol and Grimshaw have highlighted the gap between best practice based upon scientific evidence, and actual clinical care (Grol & Grimshaw 2003). They found that in the United States and the Netherlands at least 30-40% of patients do not receive care based upon current research evidence (Grol & Grimshaw 2003). In the United Kingdom there is evidence of widespread noncompliance with guidelines (Sheldon et al. 2004). This should not be surprising when consideration is given to the exponential growth of published research in relation to the time available for staff to read and implement this information. Estimates intimate that 27kg of guidelines, 3,000 new papers, 1,000 new indexed Medline articles, and 50 new randomized clinical trials (RCTs) are published each day (Coppus et al. 2007;2).

EBP continues to be founded upon an incoherent philosophical assumption that prioritizes Reliabilism, and discounts Evidentialism[37]. When it was introduced in the mid 1990s EBP had an exclusive focus upon empirical evidence. This untenable position changed when it was challenged by health professionals (Tanenbaum 1994, Feinstein & Horwitz 1997). Reactively, the proponents of EBP began to call for the

[37] This argument has a substantial, supportive bibliography from Miles et al. (Miles et al. 2002, 2003, 2004, and 2006), Norman (Norman 1999 and 2003), and in the literature on tacit knowledge, for example, (Henry 2006, Henry et al. 2007, Thornton 2006).

'integration' of some alternative kinds of knowledge, as well as emphasizing the need to include patient goals and values into clinical decision making (Sackett et al 1996). The philosophical problem which bedevils EBP is that because the authors have provided no sound philosophical argument for restricting the definition of 'evidence' in the beginning, there is now no rational for integrating the different kinds of 'evidence'. An example of this can be found in an article from Haynes at McMaster University which provides a model with overlapping circles demonstrating the integration of research evidence, patients' preferences, and clinical circumstances (Haynes et al 2002; 1350). Where this article lacks detail, is in explaining *how* the different kinds of 'evidence' integrate (Paley 2006). Tonelli argues that the few attempts to describe a method for integrating various kinds of medical knowledge and reasoning into clinical decision making have been unsatisfactory (Tonelli 2006; 249). The fundamental philosophical problem being that positivism - as expressed in the empirical hierarchy of EBP – separates questions about knowledge and value, whereas in clinical practice the two come together (Loughlin 1998, Loughlin 2002). By developing an unfounded epistemic hierarchy, EBP has driven a wedge between empirical evidence, and other forms of evidence derived by intuition, experiential learning, and expert opinion. By so doing, it has created artificial barriers between epistemology and ethics (Loughlin 2006). The individual patient and the individual clinician have been squeezed out of the equation (research evidence, clinical expertise, and patient values) involved in clinical decision making. Within epistemology, the 'evidence' mediated by perception, memory, intuition or introspection (Evidentialism) has been down-graded by EBP, in favoring empirical 'evidence' (Reliabilism). This is a significant change within health care as health professionals such as nurses, doctors and physiotherapists use inductive

reasoning in order to identify the health problem with the individual patient or client. The remaining question regards how the two schools of thought about justification of belief are to be brought together for the benefit of the patient? In other words, how is Evidentialism (which is a version of epistemic internalism (Conee & Feldman 2004)), and Reliabilism (which is in contrast a version of epistemic externalism (Conee & Feldman 2004)) to become integrated? The challenge in rehabilitating epistemic internalism is that recent epistemology has included many attacks on internalism, and a consequence has seen the development of numerous externalist theories (Conee & Feldman 2004).

Application to clinical practice.

The position described above, where positivism-via EBP-separates knowledge and value, and develops barriers between epistemology and ethics must affect the way patients are cared for within the NHS. One way to evaluate this situation is to consider what provokes individuals to complain and pursue litigation about their experience of health care. The NHS Information Centre for England reports that the highest percentage of written complaints (44.8% or 43,644) concerns the medical profession (NHS Information Centre). Nursing, Midwifery and Health Visiting make up 22.1% (21,500) of all written complaints (NHS Information Centre). When the subject of the complaints are examined, 'All aspects of clinical treatment' makes up the highest percentage of written complaints (42.2% or 42,727) (NHS Information Centre). This was followed in turn by 'Attitude of staff' (12.2% or 12,331) (NHS Information Centre). The statistic which appears to be fundamental to the current argument is that 54% of all complaints relate to *direct patient interaction (patient values) with*

healthcare professionals (clinical expertise[38]) (NHS Information Centre). These are the two kinds of 'evidence' EBP fails to integrate into clinical decision making. As a result The NHS Confederation report identifies that patient experience should examine all aspects of care delivery which includes the individual's first point of contact (The NHS Confederation 2010). It goes on to establish that 'improving the experiences of all patients starts by treating each of them individually to ensure they receive the right care, at the right time, in the right way for them (The NHS Confederation 2010)'. A project scoping carried out by NICE found that the 'Lived Experience' of the patient was a main theme (NICE 2012). 'Lived Experience' was described as;

> The recognition that individuals are living with their condition and experiencing it in a unique way, that family and broader life need to be taken into account, and that all of these aspects of lived experience can affect self-care. Taking into account individual physical needs and cognitive needs because of condition. Everyday experiences, hopes, expectations, future uncertainty, feelings of loss, feelings of being morally judged, feelings of blame. Some of these experiences originate 'outside' of the health care system but are brought with the patient into the health system; other experiences may be affected by attitudes and expectations of health professionals (NICE 2012; 48).

Such *recognition*[39] requires garnering the 'evidence' mediated by perception, memory, intuition or introspection (Evidentialism) which has been previously argued as being down-graded by EBP. The question which remains regards how the two schools of thought about justification of belief are to be brought together for the benefit of the patient?

[38] Emphasis added.
[39] Emphasis added.

Proposition-Levinas.

Tonelli (2006) provides a helpful argument that goes a long way in responding to this challenge. By proposing Casuistry, which is a term to describe case-based reasoning (Jonsen & Toumlin 1988), Tonelli highlights the importance of context. The problem which has been identified with Casuistry used in law, and in ethics, is in trying to find a similar 'case' which has a good fit with the case at hand (Jonsen 1986, Jonsen 1991).

The philosophy of Levinas, in seeking the foundation of normativity, uncovers the ethical core and key values of health care. In contrast to EBP, Levinas argues that ethics is the total resistance of reducing the other person to concepts, and therefore comprehension (Nortvedt 2003a). Rather, the other person is always other[40], and it is precisely this otherness that awakens the moral demand of responsibility (Nortvedt 2003b).

In meeting a patient for the first time, the health professional encounters the otherness of the suffering person. Here the consciousness of the doctor or nurse comes across the other, not as a concept, theme, or re-presentation, but as an infinite and irreducible other (Nortvedt & Nordhaug 2008; 159). This is what Levinas means when he proposes that ethics is first philosophy; that the intuition of ethical responsibility in the encounter with the other person cannot be reduced to comprehension (Please see figure 7 below) (Critchley & Bernasconi 2002).

[40] Levinas uses the term alterity.

Ethics	**has priority over**	***Ont/Epistem-ology***	***Law***
Call of the other		reduction via concepts	Need to establish proximity
Responsibility		Freedom	'duty of care'
Other		Same	Same
Infinity		Totality	Totality
Living-for-the Other		Living-from-the Other	Living-for-the-polity

Figure 7. Levinas' claim that Ethics is First Philosophy. **(**Adapted from Beals 2007:67).

In order to pursue a claim of clinical negligence in law, the claimant would need to prove that there were relations giving rise to a duty of care. There is a three part test for the duty of care, one of which is to prove a 'sufficient relationship of proximity' between the alleged wrongdoer and the person who has suffered damage (Deakin et al 2007; 129). Robertson proposes that at the doctrinal level in law, duties of care are imposed on the basis on interpersonal responsibility, which are driven by the pursuit of interpersonal justice (Robertson 2013; 33). The crucial point is that this is based upon 'proximity' being defined as nearness in space or time. For Levinas, it is *relational* proximity which grounds our basic ethical motivations (Critchley & Bernaconi 2002).

Nortvedt amplifies an important distinction between an ethics of proximity and other moral theories concerning moral reasons (Nortvedt 2008). He goes on to explain-drawing upon the work of Nagel-objective or agent-neutral reasons must express values that are independent of the particular perspective of the agent (Nortvedt 2008, Nagel

1986). This seems to link well with the previous discussion concerning the role of tacit knowledge in EBP (Figure 6 above), but also, more importantly, with Kierkegaard's stages of existence (Appendix 1.). That is, for Kierkegaard, the Ethical stage involves a serious engagement with the either/or of our selves[41], and the either/or of good and evil, or excludes them. Williams supports this view with his argument that always thinking impartially about attachments, personal projects and relationships tends to undermine a person's integrity, a person's sense of self, and to further distance individuals from their humanity (Williams 1988).

Proximity in the Levinasian sense is closeness understood as vulnerability, the exposedness of subjectivity to an incomprehensible, infinite otherness (Levinas 2008a). Levinas uses the metaphor of face. Importantly, this face is not a concept or a theme, but contains more than the human ego can subsume as a category of knowledge (Critchley & Bernasconi 2002). An ethics of proximity roots the conception of the humanity of humans in concrete human experiences, and the experiences that Levinas investigates philosophically are experiences of vulnerability and suffering (Levinas 2008b).

Conclusion

This argument has not been against EBP *per se.* In fact, Paley provides clear reasoning on precisely why objective research evidence is required in health care in order to reduce bias and faulty reasoning (Paley 2006). Rather, the argument has attempted to foreground the ethical dimension of care, to identify the dynamic of seeing EBP as

[41] The *authentic* self, which includes having *integrity*.

iconoclastic, and then the potential detrimental consequences to patient care where other aspects of evidence are excluded from decision making.

Further, this argument has attempted to explore the potential role for Levinas' ethical metaphysics that founds an ethical sensibility that is irreducible to knowledge, and thereby a definition of caring about the individual patient. Such a view sees the person (*face*) as more than a bio-psycho-social being-from the outside- and rather, into the experiences of the patient (Lavoie et al.2006).

Levinas' reversal of intentionality in the encounter with *face* will be considered in reviewing the literature on ethical decision making, and whistleblowing in the next chapter.

CHAPTER FOUR: LITERATURE REVIEW AND PHILOSOPHICAL ANALYSIS OF ETHICAL DECISION MAKING

Introduction.

Health care is provided to patients by a team of health professionals. The structure of this team is usually defined by the patient's health care needs. Regardless of this fact, in most care settings this will include a nurse, doctor, and a member of the Allied Health Professionals (AHPs). Crucial to this clinical encounter is the relationship between the health professional and the patient. For it is here that their respective lived worlds intersect.

The concept of *healthcare* provides a framework from which to evaluate a *good* or *poor* standard of health care. Consequently, definitions of the *good* or *poor* doctor or nurse can also be derived from this framework. In this chapter the philosophy of Aristotle, Kant, MacIntyre, and Pellegrino are considered in arguing for the internal morality for the health professions.

MacIntyre, distinguished between goods which are internal to and external to a practice. In his book *After Virtue* MacIntyre enunciates internal goods as those realised when trying to achieve the standard of excellence definitive of that practice (MacIntyre 2004). This thesis has viewed each of the health professions as a *practice*, with, for example,

excellence in caring as a good internal to nursing practice; excellence in healing a good internal to medical practice. MacIntyre defines external goods as those which do not contribute directly to the attainment of the aims characteristic of a practice. Within health care, making money would be an example of a good external to medical and nursing care.

This framework then, - consisting of an internal morality of health professions - is used in this chapter to evaluate other views of morality found in the research literature.

The overarching aim of this thesis is to explore the extent to which professionals caring for patients within the National Health Service are existentially free to make ethical decisions. The concept of existential freedom is that as proposed by Kierkegaard, Sartre and Levinas; where the individual health professional in recognising that they exist as an individual, develops a self, in order to take responsibility for others. From the patient's perspective, it is to perceive the individual as existing, and all that is in their lived world. For example, Agledahl et al (2010), when investigating doctors' moral practice found that when doctors' were taking a patients' medical history, they transformed the patients' 'diverse concerns into specific medical questions(Agledahl et al.2010;107)'. This overlooking of existential meanings and focusing on purely functional aspects of patients they called a process of 'essentialising (Agledahl et al 2010; 107)'.

Existential freedom will also be discussed in relation to whistle blowing, or what is now more commonly called the 'cause for concern' policy. There has been a long

history of inquires (Shipman, Bristol, Mid Staffordshire NHS Foundation Trust) into the NHS in the United Kingdom which has brought about one of the most prolonged investigations into the behaviour of health professionals. In conjunction with this there are an increasing number of claims and complaints made against health professionals through claims of clinical negligence. While this will be explored further in the second literature review on clinical negligence, this chapter will argue that the treatment of NHS whistle blowers is totemic of the NHS environment of conformity, secrecy and suppression.

This chapter will also explore the role of teaching in the moral development of health professionals. Specifically, the focus will be on how topics such as decision making, and ethics are taught. In many respects the definition of a good nurse, doctor, or physiotherapist are set out in the standards for education and training (NMC 2010, GMC 2009, HCPC 2012). This will be discussed in relation to an internal morality of health professions as proposed by MacIntyre, and Pellegrino.

REVIEW

Aim

The reason for undertaking this review was to thoroughly examine the empirical evidence base to test the thesis proposition that health professionals are not existentially free to care for patients. Additionally, this evidence was consulted in order to establish the dominant moral theory/s which would then contribute to later discussion of decision

making in reviewing the cases of clinical negligence, and also in developing a potential existential theory of ethics.

Review methodology

This review actually consists of a series of literature reviews which will be detailed below. The method used was as outlined in the United Kingdom Centre for Reviews and Dissemination Guidelines on Systematic Reviews (Centre for Reviews and Dissemination (2009). This involved reading the articles, and then relevant data were isolated, compared, and related.

Search strategy

An extensive search was performed in the electronic databases of Medline, Cinahl Plus, Scopus and Assia for papers published between January 1990 and February 2013. The following keywords were used; 'decision making', 'clinical decision making', 'clinical judgement', 'clinical reasoning', 'diagnostic reasoning', 'ethical reasoning', 'ethical decision making', 'moral reasoning', 'ethical practice', 'ethical action', 'ethical; behaviour', 'moral behaviour', 'moral judgement', 'ethical sensitivity', 'moral sensitivity', ethical distress', 'moral distress', 'whistle blowing', and 'cause for concern'.

Search outcome

In exploring the concept of decision making in healthcare the researchers use a number of expressions. When the term 'decision making' is used there is an instantaneous

overlap into the psychology literature, in particular to the field of judgement and decision making (Baron 2000, Gilovich et al. 2002, March 1994, Payne et al. 1993, Tversky and Kahneman 1981). There is particular salience of thought with the healthcare literature around areas of influence such as culture (Markus and Kitayama 1991, Weber et al. 2000), and emotion (Lerner and Keltner 2000, Sloman 1996). Within nursing and midwifery the most common term used is 'clinical decision making' (Buckingham and Adams 2000a, 200b Bucknall and Thomas 1997, Cioffi 1997, Field 1987, Jenks 1993, Lauri et al 2001, Luker 1992, Rhodes 1985, Thomas et al.1991). Patricia Benner uses the term 'clinical judgement' (Benner and Tanner 1987, Benner 2000, Benner, Tanner and Chesla 2009). Others (Grobe et al.1991, Higgs and Jones 2000, Kuiper 2002, Mattingly and Fleming 1994, Pesut and Herman 1992, Pesut and Herman 1999) use 'clinical reasoning'. Within medicine 'diagnostic reasoning' is common (Elstein et al.1978, Wigton et al. 1988, Offredy 1998, Offredy 2002). Some subjugate ethical with moral (Candy 1991, Chally 1992, Esterhuizen and Kooyman 2001, Parker 1990). Hamers et al. states; '…it appears that there is no unequivocal definition of decision making and that there is no consensus regarding the terminology that should be used' (Hamers et al. 1994; 54). This is no surprise when we trace the different threads back to different disciples exploring the same topic of how people behave when faced with more than one choice. Dowie has clarified between 'judgement' and 'decision making' by defining judgement as 'the assessment of alternatives' and decisions as 'choosing between alternatives' (Dowie (1993: 8). However all of the terms describe similar cognitive activities that doctors and nurses perform in making choices about patient care (Tanner 1994, Facione and Facione 1996, Rashotte and Carnevale 2004, Benner et al 2009).

The other major contributing group to healthcare is Physiotherapists. They make up 30.4% of the Allied Health Professionals (AHP), with Occupational Therapists being the second largest group with 20.4% (Scottish Executive Health Department 2002). Physiotherapists '…to a high extent still work within the biomedical frame of reference' (Gard and Thrane. 2003: 64). With physiotherapists and occupational therapists previous alliance with medicine it is perhaps understandable that the terms used by AHPs are similar to doctors; 'ethical reasoning', 'clinical decision making', and 'clinical reasoning' (Barnitt and Partridge 1997, Clawson 1994, Harding and Williams 1995, Higgs 1993, Higgs et al. 1999, Thornquist 1994).

In order to critically appraise the literature on ethical decision making, this chapter is divided into the following sections;

- Approaches to decision making
- Theoretical Analysis of Moral Behaviour (Ethical Decision Making).
- Meta ethical Fragments of philosophy.
- MacIntyre, Managerial Ethics and Relativism
- *Telos*/Ethical ends.
- Deontology
- Virtue Ethics
- Teaching ethics and Ethics pedagogy
- Discussion and Conclusion.

Approaches to decision making

One of the most striking features in the literature is the way that doctors, nurses and Allied Health Professionals (AHPs) use different approaches to decision making. This feature will be brought out in reviewing the different philosophies, core curriculum, and management structures of the key professions making up the healthcare team. The main development here has been where nurses and AHPs (previously knows as Professions Allied to Medicine (PAMs)) have gained a degree of autonomy from the Medical Model where the doctor directed the nurses and PAMs, both clinically and in management. The central debate has been over an ethics of care (Gilligen 1982) or ethics of justice (Kohlberg 1981a, Kohlberg 1981b). From this polarised situation emerged differences in approach in educational preparation, particularly between nurses and physicians (Bates 1970, Twomey 1989, Baumann et al. 1998, May & Fleming 1997, Fry 1989, Grundstein-Amado 1992, Oberle and Hughes 2001). The potential problem of differing curricula is one of '…conceptual and practical isolationism of thinking about health care ethics' (Hanson 2005; 168).

There are two overarching, predominant theoretical perspectives on decision making within healthcare: the analytic and the intuitive (Rashotte & Carnevale 2004). Dowie and Elstein (1988) provide an overview of this research to describe the cognitive processes used by doctors, with the models also being used by nurses and AHPs. The models have been identified as; the Bayesian formula of probability (Eddy and Clayton 1988, Fischhoff and Beyth-Marom 1988), the clinical continuum theory (Hamm 1988), decision analysis theory (Doubilet and McNeil 1988), the Brunswik lens model (Wigton et al. 1988), information processing theory (Elstein and Bordage 1988), and

reflection-in/on-action theory (Schön 1983). All of these theories remain relevant to healthcare and their current utility is perhaps best seen in the algorithms and decision trees used within NHS 24.

Within the analytical perspective of decision making, Bayesian inference is a popular rational model. Thomas Bayes' theorem claims that accurate decision making can rely on probability estimates based on the prior occurrence of two separate particular diagnoses with specific signs and symptoms (Swartz 1998). It is a mathematical model for revising predictions in light of relevant evidence (Encyclopaedia Britannica 2005). In Bayes model, decision making is represented in terms of hypotheses, each of which is characterised by a subjective probability, representing one's confidence in its truth. Two features of Bayesian theory to highlight are that our beliefs come in degrees of certainty, and that these degrees of belief as probabilities are thought of as subjective probabilities. That is, it can be 'perfectly rational for different people to attach different subjective probabilities to the same proposition' (Papineau 2003: 291). The theorem dictates that upon discovering new evidence practitioners will adjust their degree of belief in the hypothesis (Rashottee and Carnevale 2004). In nursing, Bayes' theorem was used in some of the first research investigating nurse decision making (Hammond 1966).

There is also increasing interest in the use of decision trees (Bonner 2001, Corcoran 1986a, Elwyn et al. 2001, Hatcher 1995, Koenig et al. 1993, Schulberg et al. 1989, Zarin and Earls 1993). Decision trees can provide structure to assist decision making in clinical practice (Carnevelli and Thomas 1993). Decision trees are a problem solving,

rational approach to assist a decision where there are mutually exclusive courses of action. Each option is objectively, or subjectively assigned corresponding expected probability and utility estimates. For example, evidence in the form of research can be added in to provide objectivity. The best decision is then computed by multiplying the probability with the utility of each outcome (Dowding and Thompson 2002). Simply stated, numerical values are given at each fork in the decision tree to add or subtract weight to each consideration and thus to substantiate potential outcomes. The literature around the efficacy of decision trees has two main findings; 1. They can improve consistency between nurses, and improve decision accuracy (Shamian 1991, Letourneau and Jensen 1998, Warren et al.1999), 2. Greater clinical experience does not necessarily cause clinicians to converge on an optimal diagnostic strategy (Elstein et al. 1978, Ferrand et al. 1992, Offredy 1998, Offredy 2002, Tanner et al. 1987, Wigton et al. 1988). Decision trees may facilitate the communication process between clinicians (Shamian 1991), and clinicians and patients (Naik et al. 2005). One of the issues with such tools is the balance of power in shared decision making which affects the process of dialogue inter-professionally, intra-professionally, and with the patient.

The dominant explanatory theory on nurse decision making until the 1980s was the hypothetico-deductive rational process based around theory from cognitive psychology (Thompson 1999). This theory which was first presented by Newell and Simon (1972) has been one of the most influential descriptive theories of decision making in medicine and nursing (Rashotte and Carnevale 2004). Elstein et al. (1978) found that medical decision making is a sequential cognitive activity where early problem identification and hypothesis generation guide subsequent data collection and

hypothesis evaluation. Similarly there have been a number of studies which have concluded that nurses make judgements about patient care using the hypothetico-deductive model (Carnevali 1984, Corcoran 1986a, 1986b, 1986c, Einhorn and Hogarth 1981, Hamers et al. 1994, Putzier et al. 1985, Tanner et al.1987, White et al.1992, Radwin 1990). An important aspect of this theory is that the human decision system can be separated into two components. One is the short-term memory that contains the stimuli information required to unlock factual and experimental knowledge stored in the long-term memory which makes up the second component (Hamers et al. 1994). This has recently been developed with the research on the role of emotion in decision making (Lerner and Keltner 2000).

The information processing model is then described as having a number of stages. Elstein et al. (1978) proposed a four stage model, based on a five year research project using medical students and qualified doctors. Carnevali (1984) describes a seven-stage process used by nurses. Radwin (1990) and Hamers et al. (1994) describe a four-stage model which contains the basic framework of Elstein et al (1978); The first stage is called ‘cue acquisition’, and involves the clinician taking part in a patient encounter and gathering preliminary clinical information about the patient. In the second stage the clinician develops a number of tentative hypotheses, based upon the gathered data and short term memory based cues. In the third stage the clinician interprets the cues gathered during the first stage and classifies them as either confirming, refuting, or not contributing to the initial hypotheses developed. This classification is then used in the final evaluatory stage where the clinician weighs up the pros and cons of each decision alternative, and chooses the one favoured, based on the quality of the evidence.

This linear process does not take cognisance of the role of emotions in decision making. Psychologists have found that positive emotions increase creative problem solving and facilitate the integration of information (Isen 1993). Estrada et al. (1994) found that doctors in whom positive affect has been induced integrate information more efficiently than do controls, show less anchoring on earlier diagnoses, and display more creativity in their thinking. Positive feelings can promote variety seeking (Kahn and Isen 1993), overestimation of the likelihood of favourable events, and the underestimation of the likelihood of unfavourable events (Nygren et al. 1996, Wright and Bower 1992). Conversely, negative affect (feelings) can produce a narrowing of attention and a failure to search for new alternatives, and people in negative moods make faster and less discriminate use of information that can increase choice accuracy in easier tasks and decease it in harder tasks (Luce et al. 1997). Similarly, Mano (1992, 1994) found that people in unpleasant moods employ simpler decision strategies and form more polarised judgements. This dynamic of the decision maker is neglected in the hypothetico-deductive rational process, and yet it is bound to affect the decision making process. Lewinsohn and Mano (1993) found that people in pleasant moods deliberate longer, use more information, and re-examine more information than others. All of this research contributes to a richer understanding of decision making in the clinical context which involves the constraints of time, and the influence of feelings. Holzemer (1986), Offredy (1998, 2002) and Elstein and Schwartz (2000) found that it was precisely when practioners were confronted with uncertain or complex problems that this approach was commonly applied to their decision making.

Albert et al. (1988) considered medical decision making as more of a cyclical model which is dynamic and iterative. Similarly, Patel et al. (1999), and Knoebel (1986) thought that medical decision making in real-time clinical situations is a combination of both forward and backward reasoning.

The analytical linear approach has also been challenged for not being able to predict the ways in which expert practitioners make decisions in ambiguous situations (Benner 1983, 2000, Benner and Tanner 1987, Corcoran 1986c, Tanner et.al 1987, Patel et al. 1999). The main proponent of intuitive decision making has been Benner (2000) within nursing, and Schön (1983) within the medical field.

Intuition was initially identified by Carper in the nursing literature (Carper 1978). Carper's (1978) work was developed upon the earlier works of Dewey (1958) and Polanyi (1962). Carper (1978) identified the fundamental importance of intuition in *Ways of Knowing in Nursing*, and this remains a seminal work. However the role of intuition in nursing practice continues to be debated (Darbyshire 1994, Effken 2001, English 1993, Gobet and Chassy 2008, Johnson 1994, King and Appleton 1997, Paley 1996).

There are many different definitions of Intuition. Effken (2001) provides a useful table with twenty two definitions of intuition. Some of the main features are; 'knowledge of a fact or truth, as a whole'; 'immediate possession of knowledge'; and 'knowledge independent of the linear reasoning process (Effken 2001: 248)'. Dreyfus and Dreyfus outlined six key aspects of intuitive judgement as 'pattern recognition, similarity

recognition, commonsense understanding, skilled know-how, sense of salience and deliberative rationality' (Dreyfus and Dreyfus 1986:50). This is very similar to the study carried out by Pyles and Stern who found what they termed a 'nursing gestalt' which was a matrix in which the nurses linked together knowledge, past experiences, patient cues and gut feelings (Pyles and Stern 1983). The nurses explained their gut feelings as recognition of the patients 'falling out of the pattern' which was the discrepancy between what the nurse's saw and what they expected to see in the patient. Theses subtle cues then provided the nurses with a feeling trigger about changes in the patients' condition. It is interesting here to see the link with the first step in the Information processing model 'cue acquisition' and the role of emotions as outlined in the psychology literature.

Benner and Tanner first defined intuition as 'understanding without rationale' (Benner and Tanner, 1987: 23)'. More recently (Benner et al. 2009), they now emphasise that knowing the patient or client, and being involved with his/her care are also key elements which strengthen the nurses' intuition. Within the context of ethical decision making Pyles and Stern (1983) highlighted the difficulty which nurses can experience in communicating these intuitive feelings to medical staff, especially when the nurses wanted doctors to take action based on their clinical judgement.

Embedded in the research on intuition is the debate about nursing as a science or art. With Banners' intuitive-humanist research approach and the more traditional systematic-positivist research approach being seen as two opposing approaches. Intuition is more often included in the art than the science of nursing (Gordon 1986,

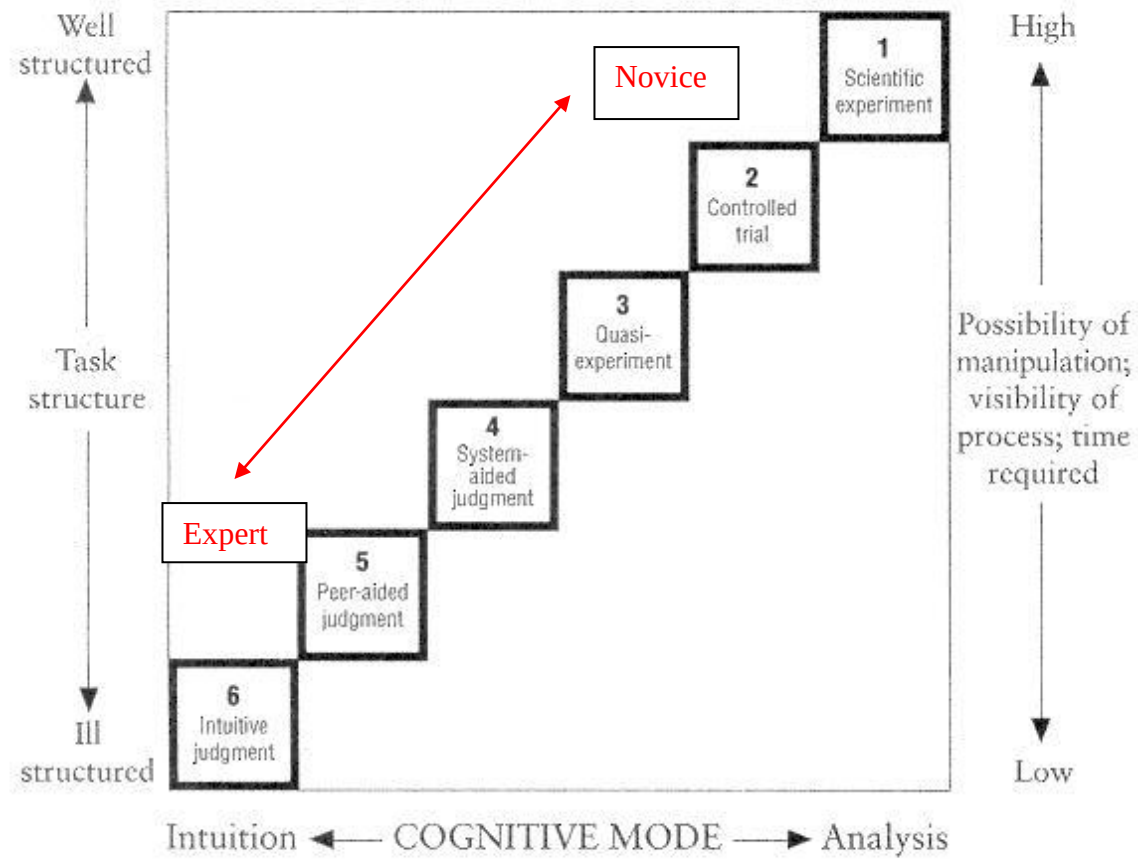
Hampton 1994, Johnson 1994, Johnson 1996a 1996b, Pyles and Stern 1983, Rew 1988, Rew and Barrow 1987). Some have argued for the two approaches as different ways of knowing (Berragan 1998), and others as two poles of the clinical decision making continuum (Thompson 1999).

The Cognitive Continuum Theory is a descriptive theory that shows how judgement situations or tasks relate to cognition. Hamm (1988) states that cognition is neither purely intuitive nor purely analytical, rather it is commonly located at some point in between. The model contains two continua; cognition, and judgement task structure. The cognitive continuum ranges from intuition to analysis, and the judgement task structure ranges from ill-structured, to well-structured (Hammond 1980, 1981, Hammond et al. 1983) (Please see Figure 4. below). According to the theory, the more structured a task is, the more analytically induced will be the decision-making mode. Equally, with an ill-structured task decision making is suggested to be intuition induced.

Because the cognitive continuum theory is based upon Social Judgement Theory it is sensitive to such variables as power, social structure, and individual knowledge (Hamm 1988). This is where it departs from the rationality of the information processing model. Thomson (1999) gives the example of an individuals' position in the structures and hierarchies in a work environment affecting how much credibility they are perceived to have. The example given is that practitioners may reject intuitive solutions from 'junior' colleagues where analytical reasoning cannot be demonstrated (Thompson 1999:1227).

When Benner's (1984) Novice to Expert framework is superimposed onto Hamm's' Cognitive Continuum, Intuition as experienced by the expert would be placed at mode 6 'intuitive judgement'. The Novice, who find themselves 'governed by context free rules as guides to action' would be at the other pole of analysis. This combined framework is then useful for seeing the debates on nursing as an art or science. Intuition is 'know how' knowledge often related to the 'art' of nursing, medicine, and physiotherapy; 'know that' knowledge is grounded in theory and empirical research and often classified as responsible for the 'science' of nursing (Thompson 1999: 1225). Foundational to this stance is that intuition is not congruent with rationalism and empiricism, 'the two epistemological positions that generally form the crux of medical discourse in Western epistemological philosophy' (Rashotte and Carnevale 2004: 164).

Figure 8. Adapted from Hamm (1988: 87).



Theoretical Analysis of Moral Behaviour (Ethical Decision Making)

Within moral philosophy there are three classic moral theories. These are known as deontology, consequentialism, and virtue ethics. They are further classified as

deontology being described as non-teleological, with consequentialism and virtue ethics as both being teleological. Reiman (1990) explains that teleological moral theories normally take the production of good consequences as the decisive feature of morally approved behaviour.

The healthcare literature on ethical decision making is predominantly based upon deontology, and to a lesser extent consequentialism, especially that of utilitarianism. Virtue ethics is not referred to in the research on ethical decision making. The main moral theory providing the framework for professional regulation and standards of conduct is deontology. This is the same for doctors, nurses, midwives, and the Allied Health Professionals (GMC 1995, GMC 2002, GMC 2006, NMC 2008, HPC 2008, GMC 2009a). However, when the health professional is presented with an ethical dilemma no indication is given as to which moral theory should take precedence, nor to which principle is cardinal within the chosen theory. This is even the case in the guidance to doctors on medical ethics (BMA 2012).

Meta-ethical Fragments of Philosophy

Kant and Aristotle had different views of what the good is. Aristotle starts the *Nicomachean Ethics* with the phrase;

> Every art and every inquiry, and similarly every action and pursuit is thought to aim at some good: and for this reason, the good has rightly been declared to be that at which all things aim (Aristotle 1998: 1).

Theories on moral behaviour in general, and ethical decision making (normative) in particular, assert themselves without any preamble regarding their meta-ethical foundations and origins. The literature within healthcare ethics is a good example of this where fragments of Kantian, Aristotelian, and Bentham's philosophy are all used simultaneously without consideration at the meta-ethical level. Yet there are many aspects of these respective philosophies which are incompatible. Alasdair MacIntyre (2004) makes this point eloquently in the opening chapter of his book *After Virtue* where he paints the world of natural science suffering a catastrophe where a Know-Nothing political movement destroys much of the systematic research process underpinning knowledge, to the extent that only fragments remain. Significantly, people continued to use the technical language of science;

> …but many of the beliefs presupposed by the use of these expressions would have been lost and there would appear to be an element of arbitrariness and even the choice in their application which would appear very surprising to us (MacIntyre 2004: 1).

Most importantly MacIntyre goes on to emphasise 'What would appear to be rival and competing premises for which no further argument could be given would abound' (MacIntyre 2004: 1,2).

Further, the subtleties within each individual philosophy are treated as an amorphous mass so that Kant stands for Deontology and duty, without further consideration of the several formulations of the categorical imperative, or indeed mention of the hypothetical imperative (Schwartz 2010). This point will be explored further in the next

section in relation to whistleblowing where instrumental reasoning may be a factor where staff keep silent in order to avoid confrontation.

Yet there is a distinction between two levels of moral thinking within Plato and Aristotle. Plato distinguishes between 'knowledge' and 'right opinion'. Aristotle distinguishes between 'virtues of character and of intellect'. Hare confirms this view in explaining;

> But it may be doubted whether its immense importance has yet been realized…it is hardly an exaggeration to say that more confusion is caused, both in theoretical ethics and in practical moral issues, by the neglect of this distinction than by any other factor (Hare 1981: 25).

MacIntyre, Managerial Ethics and Relativism

Moral behaviour does not occur in a vacuum. Rather, it is socially situated in historical time. As will be seen later, this is a feature in Kierkegaard's definition in the stages which move from the *aesthetic* which is completely immersed in the social situation, through the *ethical*, to the *religious* which is able to transcend the current context by way of the infinite. With Kierkegaard there is a movement inwards, to that single individual, and also to the infinite.

In the Greek language there are two concepts of time; *Kronos* which is clock time, and is said to be more quantitative, and *Kairos* which has a more qualitative nature, and is described variously as the 'opportune moment', or 'situational context' (Kinneary and Eskin 2000). *Kairos* gives *Kronos* a transcending value, and links human agency to

cosmic order (Zhu 2006). This historical situational context influences moral behaviour in the same way that we would consider the influence of the fluid a cell was bathed in when trying to understand its functioning. Moral behaviour is immersed in a bath of terms of reference, from time-past, but is a part of present-time (part of the whole).

This dynamic interrelationship with unstoppable, unrepeatable, time calls for a constant wakefulness to critically appraise what is happening on this meta-ethical horizon, before it becomes unquestioning practice. Tillich states 'Kairoi are those cries in history which create an opportunity for, or demand an existential decision by the human subject' (Tillich 1936). Here in the concept of *Kairos,* we can hear little motifs of what Aristotle called 'equity' in law which was defined as 'justice that goes beyond the written law' (Kinneavy and Eskin 2000), what Heidegger termed *moment* in his earlier writings, and which is developed into a full-blown theme which will be discussed in the chapter on Existentialism (Chapter 8).

Sacks (2005) agrees with MacIntyre (2004) that it is the most visual protest, the angriest voice, and the extreme slogan who win. Emotivism has become the language of morals. What we have lost is a common language and logic accessible to all so that we can reason together. John Rawls called this 'public reason' (Rawls 1993, 1999). In each of the Universalist cultures there was a greater degree of moral consensus compared to the post modern situation of global capitalism. Postmodern knowledge according to Lyotard 'refines our sensitivity to differences and reinforces our ability to tolerate the incommensurable. Its principle is not the expert's homology, but the inventor's paralogy' Lyotard (1984: xxv). It is the incommensurability of some ethical

decisions which lead to claims of healthcare negligence. Within the healthcare system there appears to be differing ends to the goods of practice. This change was pushed into the light with the introduction of competitive tendering, the introduction of NHS Trusts and the forces of the free market allowed to impact upon healthcare management. The key issue at heart was that the success of patient care was measured with a Utilitarian approach, with league tables promoting the most financially efficient hospitals and naming and shaming those who had not been able to function within their allocated budget. The main *telos* had become financial with the expectation that patients could be reduced to an inanimate commodity as measured in all other factories of the market. A practical example of this would be where some larger Trusts would perform poorly (financially) precisely because they provided complex interventions where the clinical risk was high, and patients were referred from out-with the Trusts geographical area because of their expertise, as in for example, Cardiac surgery. This is a feature of global capitalism the influence of which can also be seen within education. On discussing the concept of 'productivity' within education MacIntyre explains;

> It is a highly abstract conception of the school as an input-output machine whose activities are to be understood as transforming measurable input into measurable output (MacIntyre, 2004: 3).

As within education, the ends within healthcare have similarly changed. The challenge in both areas is the unpredictability of the commodity; in healthcare the patient, in education the student. What happens when the patient fails to comply with the standard Patient Pathway? Is the chief end of a student to pass exams? Perhaps unlike other businesses, in health care and in teaching the individual professional uses the 'therapeutic self' as the machinery through which to effect change. There is a push to

reduce patients and students into compartments in order to be financially efficient. MacIntyre (1999) terms this phenomenon 'Social Compartmentalisation' where each particular area of life is delimited, with its own norms and prescribed roles. These cultural parodies are reinforced with professional codes which encourage staff to do one's duty just because it is one's duty and not for the sake of any further end.

Telos/Ethical Ends

In the moral domain of healthcare practice it is important to consider what end we are aiming for, and to consider what the good is. Depending upon who you ask the responses could feasibly range from a good outcome for an individual patient, through to national prosperity by way of reducing illness. In evaluating the literature on moral behaviour (ethical decision making, Whistle blowing, legal cases of healthcare negligence) it seems a misconception to believe that the micro level aims of individual patient care would be subsumed in the macro level political aims, that the two levels are integrated. Manpower planning calculates the number of qualified nurses per patient within a certain level of dependency. The detrimental effect of staff shortages on patient care and staff morale has been well documented (Bowman 1995). Aristotle would ask what is the function of Nursing, Medicine, and the Allied Health Professionals? What is the function of the health service? In answering this, we would need to consider where Aristotle (1998) usefully distinguishes between the internal goods of a practice which he termed *praxis,* and those which have its end external to the practice as *poiesis.* This approach is going to be used in considering - in turn - Deontology, Virtue Ethics, Utilitarianism, and some of the philosophical issues presented in the healthcare literature.

Deontology

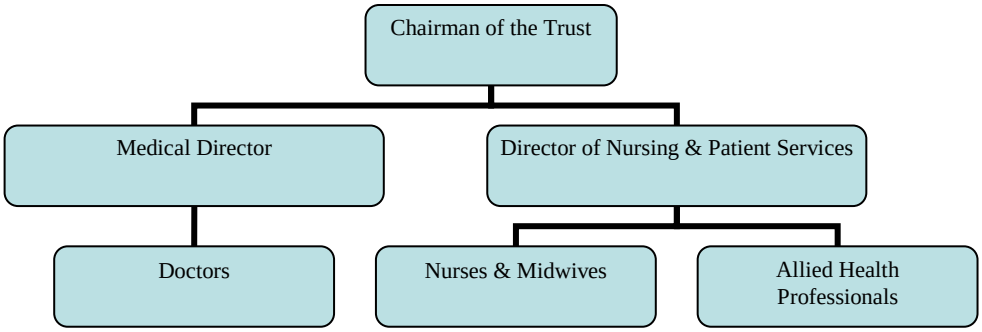
Kant is almost surgical in his incisive analysis on morality, in the way that he goes straight to the issue of 'Freedom'. He has already established that a 'goodwill' is the most important thing when he states 'It is impossible to conceive anything at all in the world, or even out of it, which can be taken as good without qualification, except a *goodwill*[42]*'* (Kant 1997a: 59). But what if that 'goodwill' is not free?

The healthcare literature, the NMC, the GMC, and the HPC, all presuppose that human agents have free will. It then follows from this premise that staff have a Categorical Imperative to care for patients, indeed, a 'duty of care' which is legally binding. The curriculum for all healthcare professionals endorses this position. When things go wrong these are the very 'duties' which are used to evaluate behaviour and actions.

It is difficult for the above situation to capture the hierarchical structure of the National Health Service and the dynamics within the healthcare team caring for the patient. Implicit in the literature is an assumption that all members of the Health care team are equal. In reality the NHS is composed of a hierarchical structure as outlined in the organisational figure below.

[42] Italics in the original.

Table 8. NHS Trust Organisational Structure.

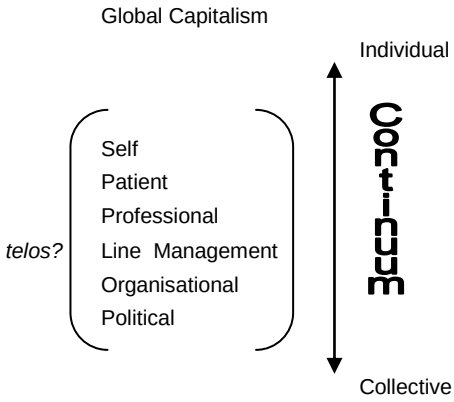


What is not evident from the chart is the medical dominance over the other professions which is perpetuated by the view that scientific evidence takes precedence. For example at the top of the research methodology pyramid is Randomised Controlled Trials. Another feature which is clear in the literature, and is reiterated in the management structure above, is the way in which the professions learn separately about ethics, approach ethical problem solving differently, and the linear management structure. These differences are demonstrated well in the case where a Consultant geriatrician asked a Sister of a Day hospital, to give a patient Haloperidol (sedative) dissolved in a cup of tea. A disciplinary hearing exonerated the Consultant, and the Sister was suspended and given a final written warning (Kellet 1996). This whole case questions the authority of the multidisciplinary team and the equity of team members. Yet central to Kantian ethics, as espoused in our professional codes and standards, is equity; 'Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end (Kant 1997a: 32)'.

While the whole team should be working towards the same strategy through annual personal objectives, this is frequently not sensitive enough to changes, so personal objectives soon become misaligned with the executive or political strategy. A practical example of this would be where NHS Trusts 'go into the red' and have to try and save millions of pounds.

Figure 9 below demonstrates some of the tensions which can arise when personal objectives are not aligned to the executive strategy. It becomes significant again to reiterate Aristotle's question of what is the function of the Health Service.

Figure 9. The *telos* of caring



The literature review on Whistle blowing and the theoretical analysis of the legal transcripts on healthcare negligence, provide themes of evidence where healthcare professionals are not free, autonomous agents. It seems from the research that we

believe we are free and using the Categorical Imperative, but the evidence seems to demonstrating we are in fact using the Hypothetical Imperative, which conditionally requires an action for the sake of some other end or purpose. With the Hypothetical Imperative the heteronomous will is subjugated to rules of action that have been legislated externally to it. This is not said to be critical of organisations, because they too are subject to this.

This point can be teased out by looking at what Kant calls 'Kingdom of ends';

> A rational being must always regard himself as making laws in a kingdom of ends which is possible through freedom of the will - whether it be as member or as head. The position of the latter he can maintain, not in virtue of the maxim of his will alone, but only if he is a completely independent being, without needs and with an unlimited power adequate to his will (Kant 1997a: 95, 96).

The challenge for a rational professional within the NHS is the extent of their freedom of will, and adequate resources ('without needs and with an unlimited power adequate to his will' (Kant 1997a: 96). At a superficial level it may seem as if individuals (and organisations) are being used as means-to-an-end, with the Hypothetical and Categorical Imperatives being a polarised debate. The cardinal question is to what extend do we perceive our freedom, and the philosophical manoeuvre to be able to conceive of ourselves in the noumenal realm as free, and in the phenomenal realm as subject to causal influences. Drummond (2007) in explaining the ancient Greek concept of *epimeleia heautou* (Care of the self), and system efficiency states;

> … it is important that these two ends, care of the self and system efficiency, are not treated as being mutually exclusive, but to embrace the *epimelia heautou* is to keep the relation between these ends in a state, not of absolute opposition, but certainly that of an enigmatic ambivalence of a perhaps longed-for harmony, on the one hand, and a permanent provocation, on the other (Drummond 2007: 264).

As previously stated this was the Internal and External goods of a practice for Aristotle. Within the Categorical Imperative there is an often overlooked aspect which emphasises the unique value of rational life in the way that it also directs backwards towards the individual; 'For rational beings all stand under the law that each of them should treat himself and all others, never merely as a means, but always at the same time as an end in himself (Kant 1997a: 95).

Virtue Ethics

The discussion thus far has considered decision making in the National Health Service, and the fragmentary nature of the underpinning philosophy is beginning to emerge. One significant point supported by Hare has been the distinction of two levels of moral thinking within Plato and Aristotle regarding knowledge and character. This point is now going to be considered further in exploring the moral paradigm of Virtue ethics.

It is perhaps of epistemic importance to note at the outset, the way in which virtue ethics is frequently presented as a contrast to act-based, and belief-based theories, such as deontology and consequentialism[43]. The sub-text being one on incompatabilism. The

[43] Examples would be Baron et al (1997), Oakley (2001) and van Hooft (2006).

extent of this suggestion is underlined by the landmark paper presented by Elizabeth Anscombe in 1958 which proposed,

> It would be a great improvment[44] if, instead of "morally wrong," one always named a genus such as "untruthful," "unchaste," "unjust." We should no longer ask whether doing something was "wrong," passing directly from some description of an action to this notion; we should ask whether, e.g., it was unjust; and the answer would sometimes be clear at once (Anscombe 1958:7,8).

Anscombe forced this debate by calling for the rejection of deontological and consequentialist theories, and as can be seen in the proposal above, wanted to shift the focus of moral evaluation away from *actions* on to *agents*[45].

The potential influence Virtue ethics can have upon developing a moral community, epistemology and ethics will now be considered.

Virtue Ethics-structure.

The roots of Virtue ethics can be traced back to Aristotle and Plato (Hursthouse 2010). In *The Nicomachean Ethics* Aristotle proposes:

> Virtue, then, is a state of character concerned with choice, lying in a mean, i.e. the mean relative to us, this being determined by a rational principle, and by that principle by which the man of practical wisdom would determine it (Aristotle 1998: 39).

[44] Misspelling in the original.

[45] In passing it is worth noting that Anscombe (1958), Macintyre (2004), and Taylor (2007) all share the analysis of reified moral theory as being substitutes for discredited faith-based axioms. This issue will be considered in more detail in conjunction with secularisation, and the influence this has upon the moral imagination in Chapter Seven.

This précis will now be explored by applying the theory to clinical practice within the National Health Service, with particular reference to the current theme under discussion in this chapter of decision making. First the structure of Aristotle's thought will be set out.

The linking of virtue (*arête*) and character places a functional definition upon human being. This is seen where virtue (*arête*) in the Greek sense is used to describe excellence in quality. Aristotle applied this not just to human being, but also to inanimate objects. The example which is often used –and links well with Sartre[46]- is that of a knife which should cut well. So anything good performs its function well and demonstrates virtue (*arête*). Thereby the good nurse, doctor, or physiotherapist would perform their function well. The aim of this virtue is the highest good (*eudaimonia*) which is usually translated as happiness or flourishing (Hursthouse 2010).

Significantly for health care pedagogy, Aristotle distinguished between *moral* and *intellectual* virtues (Slote 1995). The *moral* virtues included qualities of character such as courage, temperance, patience, truthfulness and care. Aristotle considered these being acquired by habituation.

The *intellectual* virtues were divided into art or technical skill (*techne*), scientific knowledge (*episteme*), practical wisdom (*phronesis*), intelligence (*nous*), and wisdom

[46] Sartre used the example of a penknife to illustrate how it had an *essence*, where individuals exist first, then develop an *essence*.

(*sophia*). Aristotle thought that the *intellectual* virtues were best gained by instruction (Aristotle 1998). Here then are suggested two developmental methods: habituation, and instruction.

At this juncture it may be profitable to set up a dialogue between Aristotle and Kant in order to clarify the two perspectives, for Virtue was also an aspect in Kants' moral theory, and indeed in consequentialism. Elizabeth Anscombe's paper seems to have set off a reaction principally between virtue ethics and the two other normative approaches to ethics. Instead of taking the traditional approach of contrasting virtue ethics with deontology and consequentialist theories, it may be helpful to consider any common ground[47]. Kant's main criticism of virtue ethics can be found where he stated,

> Plato found the chief instances of his ideas in the field of the practical, that is, in what rests upon freedom, which in its turn rests upon modes of knowledge that are a peculiar product of reason. Whoever would derive the concepts of virtue from experience and make (as many have actually done) what at best can only serve as an example in an imperfect kind of exposition, into a pattern from which to derive knowledge, would make of virtue something which changes according to time and circumstance, an ambiguous monstrosity not admitting of the formation of any rule (Kant 2007: 311).

Each of these criticisms is now going to be taken in turn to critically evaluate virtue ethics.

[47] Kant made the distinction between determinant judgement where a rule was applied to particulars. Whereas, in reflective judgement, the individual was presented with the particular and had to find the rule.

The Field of the Practical.

Given that both virtue ethics and the other two main normative ethical theories are concerned with virtues it is necessary to clarify what distinguishes between these theories regarding the concept of *virtue*. In deontology and consequentialism, the *act* is more fundamental than the virtues and vices. Therefore, *act*-based theories define the moral virtues and vices in terms of the right and wrong acts performed by the health professional. These acts are based upon moral principles and rules which are universal in form (van Hooft 2006:20). Similarly, belief-based epistemologies such as evidentialist accounts of justification (Evidence Based Practice), take evidence to be more fundamental that the epistemic virtues and vices (Battaly 2010: 2).

Greco and Turri (2011) provide a key explanation in distinguishing between virtue ethics and the other two main normative theories. Greco and Turri (2011) assert that virtue ethicists and virtue epistemologists would reverse the analysis, so that right and wrong acts are defined in terms of the moral virtues and vices (*actor*-based)-rather than the other way around. Therefore, virtue epistemologists take the epistemic virtues and vices (*agent*-evaluation) to be more fundamental than any type of belief-evaluation (Crisp 2010). The two approaches are then defined as virtue ethics, and virtue theory. The crucial aspect is not just the mere presence of a virtue in an ethical theory, but rather the role they play within that theory (Mcaleer 2007). Virtue ethics however, does not exclude deontic judgements nor ethical principles; rather they would be derivative from the virtues with a primary emphasis on the assessment of agents and their motives and character, as opposed to acts and choices (Slote 1992:89).

As a consequence of the reversal of the analysis, it is the virtues (*arête*) which have primacy in virtue ethics. Both the *moral* and *intellectual* virtues are required for flourishing (*eudaimonia*) as a health professional. Perhaps the primacy of *arête* is best seen in Aristotle's two books on ethics: *The Nicomachean Ethics* (Aristotle 1998) and the *Eudemian Ethics* (Aristotle 2011). Barnes traces the word Ethics as having its root in the Greek word *ĕthika* which actually means 'matters to do with character', and Barnes goes on to emphasise this point by suggesting '…and a better title would be *On Matters of Character*[48]*'* (Barnes 2000:123,124). Knowing of the great scientific work carried out in Aristotle's oeuvre, raises a question about how this reversal of the analysis would apply to any epistemology. Brown (2003) addresses this question by clarifying,

> But while Aristotle firmly believes in universals – as we saw, he believed knowledge must be of what is universal – he rejected the idea that they could exist *uninstantiated*[49] and thus independently of their particular instances (Brown 2003: 608).

This places health professionals in a bridging position between universals and the particular. While there are concepts such as 'patient' and 'vulnerable individual', it is for the doctor or nurse to *recognise* this (instantiate) in the particular patient, as an actual example. Aristotle identifies this tension when he discusses the Universal:

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[48] Italics in the original.
[49] Emphasis added. Instantiate from the Latin *instantia* 'be present'. Regarding a universal or abstract concept-represented by an actual example.

> If it be suggested that the universal is the substance of a thing, we answer: *(a)* The substance of a thing is that which is peculiar to it, but the universal is common to many. It must be the substance of all or of none. But it cannot be the substance of all; and if it be the substance of one, this one will *be*[50] the others, for things whose substance or essence is one are one. *(b)* It is that which is not predicated of a subject that is substance, but the universal *is*[51] predicated of a subject (Aristotle 1997: 208 (1038^{b}))

According to Aristotle, the virtue epistemology in such a situation (the nurse presented by the particular patient and having to apply universal concepts) would allow the health professional to act from their stable and reliable character (*arête*) (Crisp 2010). Such an account of knowledge would certainly provide a rich definition which could include the use of emotion as part of perception, and there is room for creativity and also open-mindedness towards the individual patient. However, there appears to be a potential problem here in that the individual nurse or doctor would *first* have to decide to *choose to develop*[52] a moral character. Aristotle does discuss the topic of *Conditions of the various kinds of becoming* in chapters seven to nine in his *Metaphysics* (Aristotle 1997). Some of the key aspects will now be identified below, with a fuller discussion on Aristotle's' concept of *actualization* (kinesis[53]) being held in Chapter Six.

[50] italics in the original
[51] italics in the original
[52] emphasis added.
[53] 'Crucially, kinesis is an *inner power* that grounds the individuality of existing things' (Carlisle 2005: 23).

Making an example in an imperfect kind of exposition, into a pattern.

Virtue ethics is predicated upon virtue being primary, and thereby foundational. As such there then falls out a requirement to teach virtue which includes facilitating moral development, practical wisdom, and excellence of character, so that the health professional can make sound ethical judgements in clinical practice.

Aristotle proposes that the way a health professional should learn virtue is by performing virtuous acts:

> For the things we have to learn before we can do them, we learn by doing them, e.g. men become builders by building and lyre-players by playing the lyre; so too we become just by doing just acts,| temperate by doing temperate acts, brave by doing brave acts (Aristotle 1998:28,28 ($1103^{a}33$))

While the relevance to clinical practice is perhaps immediate (we learn to become a nurse by nursing), of equal relevance is the practice of being a student. For example, by being a diligent student. With Aristotle there is always this movement from potential to *actualization*. The *moral* and *intellectual* virtues are intertwined as outlined above from Greco and Turri (2011), so that right and wrong acts are defined in terms of the moral virtues and vices. Perhaps unlike trades such a building, the health professions involve learning in theory (academia) and also in clinical practice. Most analyses of virtue theory in health care focus upon the clinical practice aspect (*moral virtue*) and *habituation,* and the instruction of the *intellectual virtues* as being more suited to the university (Psychiatric nursing-McKie et al. (2000), Nursing- Scott (1997), (2000), (2003), Medicine-Pellegrino & Thomasma (1993), Jansen (2000), Occupational

Therapy – Brockett (1996)). *If*[54] however, teaching involves instruction in moral virtue, teaching-as a practice-becomes a moral practice. This is a crucial point, as previously (pre-modernism, pre-Enlightenment, pre-Rationalism) such a discussion was not required, where now it is an issue to be considered, with far-reaching implications for the quality of patient care. Zagzebski (2010) reviews several different moral theories and establishes that they all have one thing in common, which is, they make one concept foundational. For example, in Utilitarianism the foundational concept is 'What everyone desires', in Kantian deontology it is 'Reason', and in Aristotelian virtue theory it is 'Human Nature' (Zagzebski 2010:46). Significantly, Zagzebski identifies that all of these foundational concepts is something outside ethics. At the foundation of ethics then is a question regarding the value of morality, especially when it has to be justified in terms *other* than ethics e.g. reason, human nature, or economics:

> The attraction to foundationalism, I believe, is due to the fact that in the modern era a moral theory is not only expected to justify our individual moral practices, *it is assumed that the entire practice of morality itself is in need of justification*[55], and it is assumed further that a secure foundation is the best way to justify the practice of morality (Zagzebski 2010:47).

Such a crucial question then identifies some challenges for the moral practice of health care. Particularly regarding the *telos*[56] of health care, and the role of morality in this system. In reviewing the past twenty years of the NHS market, Brerenton and Vasoodaven concluded:

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[54] *If*, because teaching could become based upon a pure economic model.
[55] emphasis added.
[56] Aristotle proposes: 'But a certain difference is found among ends; some are activities, others are products apart from the activities that produce them…the end of the medical art is health…that of economics wealth (Aristotle 1998:1 ($1094^{a}19$)).

> That said, the market reforms of the past 20 years have had unmistakable effects on the culture of the NHS. In particular, the introduction of competition has developed a system-wide awareness of costs, efficiency and accountability.
>
> However, the reforms have not been proven to bring about the beneficial outcomes that classical economic theory predicts of markets, *including provider responsiveness to patients and purchasers;* large-scale cost reduction; and *innovation in service provision*. Many researchers have attributed this to the failure to create a true, functioning market (e.g. due to political interference, weak purchasers, and barriers to exit and entry), *as well as a lack of a stable policy environment to inspire staff commitment and enthusiasm*[57] (Brerenton & Vasoodaven 2010:10).

Since virtue ethics is predicated upon virtue being primary, and thereby foundational, this requires to be clarified among other potentially competing moral theories such as Utilitarianism embedded within NHS Trust strategies. For example, the past twenty years economic analysis appears to have been successful in fiscal terms (increasing awareness of costs and efficiency), but not so successful in terms of improving the quality of care provided to patients. Such clarification is necessary as moral virtue is gained through the process of *habituation* by witnessing exemplars in a moral community. For Aristotle *moral* and *intellectual* virtues are intertwined through practical wisdom (*phronesis*) (Kerr 2011: 645.646). When the virtues are placed as foundational -as in virtue epistemology- not only is the ethical analysis reversed, so is the epistemological analysis. That is, when the doctor or nurse encounters a patient (other), it is pre-conceptual, it is the unspeakable, the undiscursive, and not subject to

[57] Emphasis added.

explanation[58]. This is the opposite of the more familiar epistemology, where concepts are applied to the other, in order to define the other[59]. In caring for vulnerable patients this appears to be a valuable point in Aristotle, for on occasions patients must be cared for prior to any specific nursing problem being identified, or prior to any medical diagnosis being considered. Zagzebski (2010) clarifies this epistemic argument by using the example of gold, where people knew of its value and use for millennia prior to knowing the nature and atomic structure of gold. In this way, virtue epistemology contributes to health care research by precisely valuing the unspeakable aspects of patient care. This poses a challenge to health care professionals as the unspeakable is prior to rationalism, ethical rules and principles, and crucially prior therefore to economic analysis

In contrast, virtue ethics, (which includes virtue epistemology) captures this rich aspect of health care through the development of character. It is the intellectual agents and communities that are the primary source of epistemic value and 'the traits constitutive of their cognitive character' (Greco & Turri 2011). Hudson states:

> The unity of character is extremely labyrinthine. It couples systematically a person's values, choices, desires, strength or weakness of will, emotions, feelings, perceptions, interests, expectations and sensibilities (Hudson 19896:)

The development of character then becomes a powerful process, via *habituation* and teaching. Before outlining some specific aspects of facilitating development of the

[58] Kant. *Determinant judgement* where a rule was applied to particulars.
[59] Kant. *Reflective judgement*, where the individual was presented with the particular and had to find the rule.

virtues, it is worth highlighting once again, that the teachers and exemplars must first have chosen the ethical life[60]. Otherwise, both processes (*habituation* and teaching) can potentially facilitate the *vices*[61]. This point is identified by Aristotle where he proposes;

> And the corresponding statement is true of builders and all the rest; men will be bad builders as a result of building well or badly. For if this were not so, there would have been no need of a teacher…
>
> …by doing the acts that we do in our transactions with other men we become just or unjust, and by doing the acts that we do in the presence of danger, and by being habituated to feel fear or confidence, we become brave or cowardly (Aristotle 1998: 29 ($1103^{a}33$)).

From this it is clear to see that Aristotle identifies the need for a teacher, and also the role of a guide in the *habituation* process. There are two main opposing views on Aristotle's theory of *habituation* (Kerr 2011). The debate centres on the role the intellect plays in informing us of the ends to pursue (Moss 2011). Principally, the 'intellectualists' think that Aristotle gives the task of informing us of the ends to pursue, not to character (virtue) but to the intellect (Moss 2011). Moss clearly argues that Aristotle intends *moral* virtue (character) to inform us of the ends to pursue (Moss 2011). This is important to health care, and the education of health professionals, as the development of character is not informed by the intellect. Rather, character involves

[60] The ethical and the political (economic) aspects of health care are not exclusory concepts. Aristotle purports that 'For even if the end is the same for a single man and for a state, that of the state seems at all events something greater and more complete whether to attain or to preserve; though it is worth while to attain the end for one man, it is finer and more godlike to attain it for a nation or for city-states (Aristotle1998:2 ($1094^{a}19$)).

[61] This will be discussed on a number of occasions later in the thesis under the concept of *totalisation.*

something that precedes rational cognition, which is non-rational cognition. Both Moss (2011) and Kerr (2011) identify the conceptual confusion on the conflation of equating the non-rational with the non-cognitive. Having reviewed the alternative (intellectualist) views Moss concludes:

> In sum, then, the burden of proof is squarely on the Intellectualists: on a straightforward, textually and philosophically defensible reading of both ethical works, virtue is solely a non-rational state (Moss 2011:214).

With the development of character then based upon non-rational cognition, this places a significant role on perception, imagination, and the emotions. Sherman argues that virtuous action is preceded by discriminating perception which includes reactive emotions, along with desires and beliefs about the situation (Sherman 1999:247).

Some of the principles in teaching *moral* virtue- as non-rational cognition can now be outlined. Aristotle has emphasised the need to perform acts in order to develop virtue by *habituation*. There is then a requirement to provide multiple and various opportunities for students and health professionals in order to have exposure to such situations. Because these experiences are not subject to explanation the student/health professional will need an exemplar. It might be difficult –even in a quasi-market environment of the NHS-to explain why caring or compassion are important. Aristotle goes against the tide of Evidence Based Practice by suggesting,

> Nor must we demand the cause in all matters alike;| it is enough in some cases that the *fact* be well established, as in the case of first principles; the fact is a primary thing and first principle. Now of first principles we see some by induction, some by perception, some by a certain habituation, and others in other ways (Aristotle 1998; 14 (1098^{a}15)).

For Aristotle, it is not always necessary to know the reason *why* something like caring matters, it is sufficient *that* something has been shown to matter[62]. In teaching *moral* virtue Aristotle suggests it is pointless to engage in argumentation. Rather that it becomes evident through experience. Health care students and professionals then experience and witness this in their myriad encounters within the health care community, which includes university life. The focus then is on *how* one interacts with students, patients, and relatives; rather than what one knows or what explanation is given. Caring, compassion and kindness are evidently virtues as seen through direct perception, as experience.

Virtue Ethics and Decision Making.

The criticism made of virtue ethics is that it does not detail how one should act, or how you would decide taking a virtue ethics approach. However, this could be seen as a *tu quoque*[63] argument as in deontology there is the potential for two rules to collide, or two ethical principles.

[62] Kierkegaard says that subjective truth is a matter of *how*-how one lives-whereas objective truth is a matter of *what* one know or believes. Kierkegaard also claims that the essence of the human subject is not reason, but passion. This will be discussed in a later chapter.
[63] Latin 'You too'. The appeal to hypocrisy. Logical fallacy.

In decision making virtue ethics provides rich information which is overlooked in both deontology and consequentialism. Vulnerable patients are sometimes unable to put into words how they feel due to physical or mental ill health. The development of character provides an ethical sensitivity to the other that involves motivation and passion. It is a settled disposition which is consistent over time and is orientated outwards toward the patient.

The next section will consider how ethics is taught within the health professions.

Teaching Ethics and Ethics Pedagogy

Background

There has been a lengthy debate in the literature on how best to assist students and health care professionals to provide the best care to patients, by doing the good or right thing. Hattab (2004) provides a useful overview of how ethics has developed in medicine from the Hammurabi Code of 2000 BC which defined the duties and rights of Babylonian surgeons, through to the Hippocratic Oath of 400 BC which emphasised the classical principles of: ‘fidelity to the patient’, ‘beneficence’, ‘non-maleficence’, ‘truth telling’, and ‘confidentiality’. Purtilio (2000) and Swisher (2002) have given a similar overview of ethical practice within Physical Therapy (Physiotherapy). These two historical analyses combined with the Nursing and midwifery literature shows the various branches (‘Nursing’ ‘Physiotherapy’ ethics) of professional ethics emerging from biomedical ethics. This is not surprising due to the Medical model being

predominant at this time. Purtilio demonstrates the effect of this philosophy in a statement from a draft professional code of 1935

> Diagnosing, stating the prognosis of a case and prescribing treatment shall be entirely the responsibility of the physician. Any assumption of this responsibility by one of our members shall be considered unethical (Purtilio.2000: 114).

The progress in bio-medical sciences and technology has transformed health systems, healthcare organisations, and presents a continual flow of ethical dilemmas, and a movement away from the simple doctor-patient relationship, to one which incorporates the health care team and the patient's family. At key times in history the health care curriculum has been advised to adapt the teaching of ethics, due to inquiries such as Shipman (Smith 2004) and Ledward (Ritchie 2000). Examples influencing the medical curriculum are the Pond Report (Institute of Medical Ethics 1987), Tomorrows Doctors (GMC 1993, 2009b), and the UK Consensus Statement (The Institute of Medical Ethics 1998). There have been similar recommendations for Nursing (UKCC 2001), Social Work, and Allied Health Professions (The Chartered Society of Physiotherapy 2002, 2011).

One major influence upon the teaching of ethics has been with the move away from the Medical model where there has been an increase in clinical autonomy for nurses and AHPs. However the lines of accountability are not clear due to all of the health care reforms. A practical example of this would be where the Consultant surgeon advises the nurses and physiotherapists about the care the patient should receive; however, they

are not managed by the surgeon. This has become more complex recently where the medical staff have lost some of their power in that they are more accountable to the NHS Trust managers and Chief Executive. This very point was beautifully demonstrated by the series of documentaries developed with the Open University when the experienced businessman, Sir Gerry Robinson (2007) tried to implement change at Rotherham NHS Foundation Trust. After discussing changes with the Consultants, nurses and managers he stated; 'I had absolutely no idea what I was taking on. I knew it was going to be tough but it was one of the most difficult challenges I have ever attempted Robinson (2007)'. The historical development of the health care team is important in analysing the current ethics situation, and in considering the future. As previously stated, the doctor was in charge of the patient, with nursing and the other members of the health care team subjugated to the doctors' control. With increased autonomy nurses, midwives and AHPs faced more clinical dilemmas. In the past, nurses and AHPs were expected to be obedient without question and did not participate in ethical decision making. The exception here is Clinical Psychology which has been more aligned to medicine, and has remained more dominated by scientific concepts (Solbrekke and Jensen 2006).

Rationale for Ethics Content in Teaching

From the above changes the content of ethics teaching has been prescribed both within universities, and in Continuing Professional Development (CPD) within health care. These changes are also part of the implied social contract professionals have with the society they work in. Part of this contract has always been that society grants monopoly status to professions as the professionals will put client's interests above their own.

This altruism has always underpinned this fiduciary relationship, with ethical practice being of prime importance (Hilton & Slotnick 2005). Through the process of maintaining the public's confidence an ever increasing list of ethics topics is developed for inclusion in the health care curricula and CPD, examples of which can be found in Miles et al (1989), in the UK Consensus Statement (The Institute of Medical Ethics 1998), Goldie (2000) and Goldie et al. (2002). Swisher provides a comparative diagram of the periods of ethics in medicine and Physiotherapy with medicine going through the three stages of: 'Proto ethical' (1960-1972), 'Philosophical Bioethics' (1972-1985), and 'Global Bioethics' (1985- present) (Swisher 2002). Physiotherapy has gone through the stages of 'Ethical Self identity' (1935), 'Patient Focused Identity' (1950s), and the future is 'Societal Identity'. Both Physiotherapy and medicine recognise that the broad problems presenting in the future will require many disciplines and 'nested' in what society requires. However, the current ethics content and delivery does not appear to be effective in nursing, medicine, social work, and the Allied Health Professions (AHPs). Nurses and midwives experience three recurring themes within the range of problems in the literature; 1) Nurses are concerned about ethical problems but take no action, or are overruled by medical staff, or cannot overcome the perceived barriers and suffer moral distress (Penticuff & Walden 2000, Sleutel 2000, Fry et al 2002,Grady et al.2008, Lützén et al.2003, Redman & Fry 2000, Schluter 2008); 2) Newly graduated nurses do not assert themselves when they experience moral conflict, instead they look for ways to cope with their own moral distress, which involves compromise and not implementing the right care (Kelly 1998, Dodd et al. 2004); 3) Nurses who do take ethical action can find themselves isolated and ostracised by other staff, and try to find

ways to promote their own moral survival (Spence 1998, Sundin-Huard & Fahy 1999, Woods 1999, Wurzbach 1999, Rodney & Varcoe 2001, Gaudine & Beaton 2002).

In a similar fashion the medical curriculum has been evaluated and found wanting. One of the key critics was Hafferty and Franks (1994), and although their findings were more than a decade ago, they are still influential today. They had two key points. The first was that while it is possible to teach information about ethics, this in no way can decisively influence a student's personality or ensure ethical conduct. Their second line of argument has been very influential, this is where they considered that most of the critical determinants of a doctor's identity operate not in the formal curriculum but in a more subtle less officially recognized 'hidden curriculum' (Hafferty & Franks 1994, Lempp & Seale 2004). There are a number of recent studies which would support Hafferty & Franks 1994 work. Rennie & Crosby (2002), when exploring medical student's inclinations to whistle-blowing, found that the number of students willing to report misconduct declined over the five years of the medical curriculum. Goldie et al. (2004) found that while the first year of the medical curriculum had a positive impact on student's potential behavior on facing ethical dilemmas, the remainder of the curriculum had a detrimental effect. The concept of the 'hidden curriculum' and the process of moral enculturation have been the focus of a number of research studies which have evaluated the deterioration in students' ethical abilities as they 'progress' through the medical curricula (Self & Baldwin 1998, Patenaude et al. 2003, Lemonidou et al. 2004, Solbrekke and Jensen 2006).

Specific Content Being Taught

Due to the traditional roles of the health care team being an aid to the doctor, the ethics syllabus for the others in the team was one on the science of conduct, based upon duties and obligations to the doctor. The literature is organized into philosophical or normative ethics which considers what 'ought' to be done on a rational basis, and social scientific or descriptive ethics which describes human ethical behavior. Within the philosophical branch, metaethics includes Deontology, Utilitarianism, Care, Virtue, and principle approaches to ethics. The specific content being taught to health care professionals has been principalism, deontology and consequentialism. Parsons et al (2001) found the dominant approaches in nursing education in the United Kingdom was one of deontology and consequentialism.

Teaching Methodology

There has been much debate about the benefits of interprofessional learning (Glen 1999, DOH 2007, Kennedy 2001, McPherson et al. 2001, Kennard 2002, Wakefield at al 2003, Tunstall-Pedoe 2003, Glen and Reeves 2004, Hanson 2005, Reeves at al 2006). A number of systematic reviews investigating Interprofessional Education (IPE) have found very little reliable evidence. Zwarenstein et al. (2001) found no studies on IPE which met their inclusion criteria. Other reviews found weaknesses in the research (Barr 2000, Reeves 2001). When Ross and Southgate (2000) carried out a survey of medical and nursing schools in 1996, they found only three examples of shared learning. It is also important to consider what the purpose of interprofessional learning was. In the government documents the aim of this education is to develop a more flexible, responsive, collaborative workforce, where the rigid differentiation between

professions is reduced, and thereby increasing the opportunities for role substitution. Glen and Reeves (2003) highlight some of the conceptual confusion in these documents, in that they use the term ‘multiprofessional’ which is defined by CAIPE (Barr et al. 2000) as ‘an educational activity where learning is shared passively’ for example when doctors and nurses share the same lecture. In contrast ‘Interprofessional education’ uses interactive approaches between professionals to encourage collaboration. The challenges in any Interprofessional education (Interprofessional because only this will achieve the desired outcomes), but especially interprofessional ethics education is achieving the balance where the individual has their own professional identity before this becomes blended in to another professional group. Parsell and Blight (1998) stated that one of the key aspects of successful interprofessional education is that students must be secure in their own identities as professionals, and Brown et al (2000) details the problems for effective collaboration when boundaries are not clear. This seems to be a key consideration when analyzing the research from the different professions of nursing, clinical psychology (Solbrekke & Jensen 2006), social work (Clark 2006), medicine (Goldie 2000, Hattab 2004, Hilton & Slotnick 2005), and the Allied health professions (Purtilo 2000, Swisher 2002, Edwards et al 2005). If only the enculturation process is examined as an example, there are huge variations between the professions, with nursing students having clinical placements immediately, medical students (on the whole) not having a placement until the fourth year, and the other professions having various blocks of time on placement. At this point it is worth considering what is the aim of the curriculum for each professional group, as perhaps this is pertinent in establishing the moral ends of the professions. If a reductionist approach is taken, and an Integrated Care Pathway (ICP) used as a model, then on paper we see the patient is

admitted by the nurse, operated on by the surgeon, received back to the nurse, with the physiotherapist having key interventions, and social workers and clinical psychologists only being called in if deemed necessary. On this patient pathway, it can been seen that 'And all the men and women merely players, They have their exits and their entrances' (Shakespeare 1979:501). Each has a different clinical and moral end, and this situation is extended to patients collectively within managed care, within the strategic ends of the health care system. The various curriculi are designed to provide each professional with the clinical competence to function in these distinctive acts. This is supported in the studies carried out by Mann et al. (2005) investigating perceptions of roles amongst doctors and six other professions revealed statistically significant differences between the groups on two main factors 'Teamwork and interprofessional skills' and 'Communication and interpersonal skills'. Similarly, Tunstall-Pedoes' study (2003) emphasizes the preconceived attitudes professionals groups have of each other. Some have argued that there is a different moral framework underlying the different professional roles, so that medical staff take an 'ethics of justice', nurses an 'ethics of care' (Baumann et al 1998).

It is also worth highlighting the dichotomous way in which the healthcare professions curriculum is delivered with a deontic approach to teaching ethics, and the socialisation process being used for a much wider range of clinical skills. Here we have almost reversed Aristotles' approach in that moral virtue was acquired through exercising the virtue, '…while moral virtue comes about as a result of habit…' (Aristotle 1998: 28).

Discussion and Conclusion

Kant and Aristotle had different views of what the good is. Aristotle starts the *Nicomachean Ethics* with the phrase,

> Every art and every inquiry, and similarly every action and pursuit is thought to aim at some good: and for this reason, the good has rightly been declared to be that at which all things aim (Aristotle 1998: 1).

Crucially, Aristotle locates this good within individuals as part of their psychological make up. This can be seen where he states 'Virtue, then, is a state of character concerned with choice…' (Aristotle 1998: 39). This approach is supported in the literature because it recognises the dynamic of the decision maker, in psychology (Baron 2000), the influence of culture (Weber & Hsee 2000) emotion (Lerner 2000, Slowman 1996, Learner and Keltner 2000) mood (Estrada et al 1994), and the relational aspect of working in a team (Gilligen 1982).

Unlike Aristotle, Kant proposes that the moral worth of our action does not reside '…in the purpose to be attained by it, but in the maxim in accordance with which it is decided upon (Kant 1997a: 65)'. Kant focuses on the question of what ground humans can resort to in establishing action guiding rules that are valid for all (Heubel and Biller-Andorno 2005). As a non-teleological theory, the deontological approach is based upon maxims, rules and principles. The principles approach remains very popular in the healthcare core texts on ethics, in for example (Gillon 1986, Edwards 2009, Beauchamp and Childress 2008) This is despite sustained critiques from Clouser

and Gert (1990), Clouser (1995) and Davis (1995). These same rules can be identified threaded through the various professional regulatory bodies such as the General Medical Council, Nursing and Midwifery Council, and The Health Professions Council (GMC 1995, GMC 2002, GMC 2006, NMC 2008, HPC 2008). One of the major flaws within deontology is that it fails to explain how to settle conflicts between moral principles and obligations (Davis 1991, Hurst-house 1999). A simple example of this would be where the nurse has a duty of care to the patient;

> (1.4 You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.), to be their advocate, and to work co-operatively within a team (4.2) You are expected to work co-operatively within teams and to respect the skills, expertise and contributions of your colleagues. You must treat them fairly and without discrimination) (NMC 2008).

This suggests the question, Is their primary duty to the patient or to the team? The Teleological approaches of consequentialism and utilitarianism to ethics is largely missing from the ethical decision making literature. Yet this is an approach used on a daily basis by health care professionals. If we take the example of rationing of health care Nurses, doctors and Allied Health Professionals always have to consider the best outcome achievable with the available resources. From the literature on rationing (Clarke 2001, Wells 1995, Botes 2000, Coast 2001, Syrett 2007, Moreira 2011, Mikochik 2011) we can see that a teleological approach is used at the micro level of trying to do the best for the greatest number of patients in your care, up to the macro or strategic level of management where the greatest good is being achieved for a given population on a set budget.

The next section (Whistleblowing) will review some of this theory on ethical decision making as applied to the specific scenarios individuals found themselves in where they felt they had to blow the whistle.

WHISTLEBLOWING

The previous review of the literature explored what staff *ought* to do based upon normative ethics, the next section will explore the literature on how staff act when confronted with a poor standard of care. This discussion will evaluate the existential theme of freedom. That is, the free will to act.

Etymology

The first identified use of the term 'Whistle-blower' was on the twenty third of March 1970 in the New York Times (Pearsall and Hanks 2003). Interestingly, one of the definitions of 'Whistle' is of a person who speaks on behalf of another as 'an instrument' or 'mouth-piece'. This definition can be traced back to Wycliffes' translation of the Bible from the Latin Vulgate in 1380. It is from the Latin root for 'called to speak on behalf of another' (*advoc$\bar{a}$tus)* that we get our term 'Advocate'. It is therefore perhaps not surprising that the literature on Patient advocacy is also relevant here (Chafey et al. 1998, Watt 1997). There is more than one theory on whistle blowing. Hunt (1995) gives the genesis to referees drawing attention to a foul in a game, while others say it is derived from British police constables blowing the whistle to warn the public of danger and to alert other officers in the area. According to King (1997) and

Miethe & Rothschild (1994) the most commonly used academic definition of whistle blowing is “the disclosure by organization members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action (Near & Miceli 1985, Miceli & Near 2002). Judd (1999) states that Whistleblowing is comparable to the shrill sounding noise of a whistle piercing the background noise and disrupting the false harmony or imposed silence of the status quo. De Marias’ definition alludes to the philosophy of Aristotle and Schopenhauer when he explains;

> …a concerned citizen, totally or predominantly motivated by notions of public interest, who initiates of her or his own free will, an open disclosure about significant wrongdoing directly perceived in a particular occupational role, to a person or agency capable of investigating the complaint and facilitating the correction of wrongdoing (De Maria 1995).

Specifically, it alludes to the tensions within citizenship, and freedom of will. Some authors (Weiss 1994, Ray 2006, Hunt 1995,Wilmot 2000) also distinguish between ‘internal’ where the whistleblower talks to people higher up in the organization, or ‘external’ where it is reported to the media, or public interest groups. Rothschild & Miethe (1999) found that nearly all whistle-blowers first report perceived wrongdoing to parties within their organizations.

Whistleblowers are a useful group of people to study when exploring moral behavior. Their actions take place in complex organizations, in situations of ambiguity and lack of moral clarity. Their displayed actions take place in the real milieu and are well

documented in inquiry reports and legal transcripts. From this the organisational ethics, reference to professional codes of conduct, and personal values can be explored.

Search Strategy

A search for the literature on Whistleblowing was carried out on the following electronic databases; International Bibliography of the Social Sciences (IBSS) (1951-2007), MEDLINE (1996-2007), Cumulative Index to Nursing & Allied Health Literature (CINAHL) (1982-2007), and the British Nursing Index (BNI) (1985-2007).Both CINAHL and MEDLINE yielded fourteen articles of research in English, there were no articles on Whistleblowing to be found via the BNI, and seven research articles within the IBSS. There are a number of literature reviews which cover the earlier material (Bowman 1983, Miethe & Rothschild 1994), and a more recent one in the journal 'Annual Reviews in Control' (Hersh 2002) on the ethical issues and conflicts of loyalties which arise in whistleblowing. The English language literature on whistleblowing focuses to a large extent on, business (Mesmer-Magnus & Viswesvaran 2005, Chiu 2003, Uys 2000, Miceli & Near 2002), legal (Vickers 2001, Burrows 2001), and healthcare (McDonald & Ahern 2000, Ray 2006, Vinten & Gavin 2005, Hunt 1995, Hunt 1997, Paul 2000, Davis & Konishi 2007, White 2006, Hannigan 2006, Peternelj-Taylor 2003, Faugier & Woolnough 2002, Rennie & Crosby 2002,) with two well-developed streams within this research which are; (1) identifying the antecedents to a whistleblowing event, and (2)the retaliation which occurs.

Professional Codes of Conduct

The General Medical Council (2006, 2009a, 2009b), Health Professions Council (2008), and the Nursing and Midwifery Council (2004) all provide guidance on Whistleblowing within their respective professional codes of conduct. All of the professional codes are written from a deontological philosophical framework. Professionals are informed they have a duty towards patients, and the specific duty is a 'duty of care'. This duty to put patients' interests first and act to protect them must override personal and professional loyalties. In the GMCs core guidance for doctors Good Medical Practice (2009a) it states 'You must protect patients from risk of harm posed by another colleagues' conduct, performance or health'. Regarding whistleblowing, the GMC advises that matters should be resolved internally, and if this is not possible 'independent advice' should be sought;

> If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them (GMC 2009a).

The guidance to doctors with a management role is that they should, 'ensure that reporting procedures are in place and that staff are aware of them', and that they should 'respond promptly and professionally to incidents and complaints (GMC 2006)'. The NHS complaints system is a failing system. Last year it received more than one million complaints, with an increasing proportion going to independent panels because of

dissatisfaction with the responses (Revill 2007). Although the government has promised to overhaul the complaints system, there are no plans to introduce the new reforms until 2009. The HPC offers similar advice to the 13 professions it regulates;

> You must protect patients if you believe that they are threatened by a colleague's conduct, performance or health. The safety of patients, clients and users must come before any personal and professional loyalties at all times. As soon as you become aware of any situation that puts a patient, client or user at risk, you should discuss the matter with a senior professional colleague. If you feel that you cannot raise the matter with a senior colleague, you can contact our Registrar (HPC.2008).

The guidance to nurses, midwives and specialist community public health nurses is more similar to that provided by the HPC than the GMC, in that it is more about 'Internal' whistleblowing:

> Where you cannot remedy circumstances in the environment of care that could jeopardise standards of practice, you must report them to a senior person with sufficient authority to manage them and also, in the case of midwifery, to the supervisor of midwives. This must be supported by a written record (NMC 2008: paragraph.8.3).

The only reference to 'external' whistleblowing is '…you should be aware of the terms of legislation that offer protection for people who raise concerns about health and safety issues' (NMC 2008: paragraph 8.2). The International Council (ICN) Code of ethics for nursing does not provide any clear guidance on whistleblowing other than: 'develop mechanisms to safeguard the individual, family or community when their care is endangered by health care personnel' (ICN.2006:3). The striking fact within nursing

is that nurses are unfamiliar with their own ethical codes. Esterhuizen found in 1996 that nurses were unfamiliar with professional codes (Esterhuizen 1996). These finding were supported by other quantitative studies at the time (Tabak & Reches 1996, Whyte & Gajos 1996). Some ten years later the situation is unchanged. An international research project aiming at harmonising ethical standards for nursing practice and the nursing professions in Europe called *Ethical Codes in Nursing* (ECN 2005), has found that nurses are not familiar with the content of their codes, and that they make only limited use of them in clinical situations. Heymans (2007) study similarly found that Dutch nurses were unfamiliar with their codes, and that there was limited dissemination, implementation and functioning of codes of ethics. A similar study of Finnish, Greek and Italian nurses found that their knowledge of the codes was poor, and that healthcare managers were not sufficiently committed to the values of codes (Heikkinen et al. 2006). Some would argue (Meulenbergs et al.2004) that due to the modernizing National Health Service codes are of limited use, and that we need to move to a more 'relational ethics' (Thompson 2002, Tschudin 2006, Ray 2006, MacDonald 2002). Nurses are unfamiliar with the guidance within their own professional codes on whistleblowing. Despite this unfamiliarity the Bristol Royal Infirmary Inquiry (Kennedy 2001) recommended that the relevant codes of practices for nurses, doctors, allied health professions, and for managers should be incorporated into their contracts of employment. When Paitison (2001) appraised the NMC Code of Professional Conduct he concluded …because of terminological inexactitudes and confusions, lack of helpful ethical guidance'…the code was 'ethically inadequate'.

Silence or Whistleblowing

Within healthcare and corporate life there is a body of literature which comprises of both disasters where nothing was said by employees until after the event, and very public whistleblowers. Within healthcare the public psyche can readily recall such cases as Graham Pink (Brindle 1990, Pink 1994),Beverly Allitt (Clothier 1994), the Personality Disorder Unit at Ashworth Special Hospital (Fallon et at. 1999), Rodney Ledward (Ritchie 2000), the consultant anaesthetist, Dr Stephen Bolsin at Bristol Royal Infirmary (Kennedy 2001), Alder Hay (Redfern 2001), and Dr Harold Shipman (Smith 2004). There is a similar history within business, and it is profitable to follow the reports. In the Oil industry the Piper alpha disaster was the first (Cullen 1990), and more recently the Brent Bravo (Harris 2006, Macalister 2006). In the rail industry, Clapham Junction (Hidden 1989), Paddington (Cullen 2000, Clark 2004), Potters Bar (HSE 2003), and most recently Grayrigg in Cumbia (Jowitt and Smith 2007). If there is any commonality in reviewing these distressing reports, it is the difficulty in raising concerns within an organisation. Fuller (1999) found that much of the evidence in accident causation suggests that managers have to balance the *competing* [*italics in the original*] requirements of safety with their other responsibilities. In their review of the empirical literature on leadership and safety outcomes O'Dea and Fin (2003) state 'numerous studies have found that pressure to achieve high production targets is implicated in accident causation'. A regular finding of these studies is that dangerous practices are tacitly encouraged by management even though they contradict formal safety policies. When injuries occur such actions can be labelled human error since they are contrary to company safety policy. Graham Pink (1994) spent two years raising his concerns in 43 letters, some of which are printed in The Guardian

newspaper (Brindle 1990). Along with the 'tacit encouragement of dangerous practices' seems to be the insidious nature of it becoming common practice. When the Ward manager (Mr Moran) was questioned about how a child could be allowed to visit two convicted paedophiles on his ward he replied '…you aspired to go to Lawrence ward, you earned the right to go on Lawrence ward, because it was operated on low staffing. They have wine and cheese parties. It was a slow insidious process that the invasiveness of such things as searching ceased' (Fallon et al 1999: 3.12.1). Some may argue that these are just isolated cases, and that with the passing of the Public Interest Disclosure Act in 1998 (1998, DTI 2006), and the launch of the charity Public Concern at Work (PCaW 1993) that whistle blowing would be far more effective. Vinten and Gavin appear more accurate when they surmise,

> '…It would almost be possible to write a common core report that would readily apply to every type of disaster; the findings of previous reports concealed or not actioned; lack of independence or effectiveness of inspectorates; failure to adopt a participative management style and, worst the 'not required back' stamp for those employees who dare complain of health and safety abuses' (Vinten & Gavin 2005).

Writing in 2003 Associate Professor Bolsin outlines the heartache and agonizing time he and his family went through once he had exposed the problems with paediatric cardiac surgery at the United Bristol Healthcare Trust (Bolsin 2003). Far from welcoming his concerns, the new Chief Executive of the Trust wrote to him stating;

> …I must make it clear that I am deeply disappointed at the information about your previous activities that has come to my attention since your departure, and I know that my concern is shared by the Trust Board (Bolsin 2003:294).

In the oil industry a senior consultant to Shell is going through a similar process. He brought his concerns to the attention of the directors of Shell as far back as 1999, and then again in 2004, but he still feels safety is compromised. Interviewed in the Guardian (Macalister 2006) Campell states "I am sorry to have to go public on this but if the current safety regime demonstrated by the Brent Bravo (fatal accidents) case study has failed and if improvements are not undertaken another major accident is inevitable". Vinten and Gavins (2005) comment on 'the findings of previous reports not actioned' can be found within the Paddington Inquiry where it states,

> There was a lamentable failure on the part of Railtrack to respond to recommendations of inquiries into two serious incidents, namely the accident at Royal Oak on 10 Nov.1995 and the serious SPAD (Signal Passed at Danger) at SN109 on 4 Feb 1998 (Cullen 2000:3).

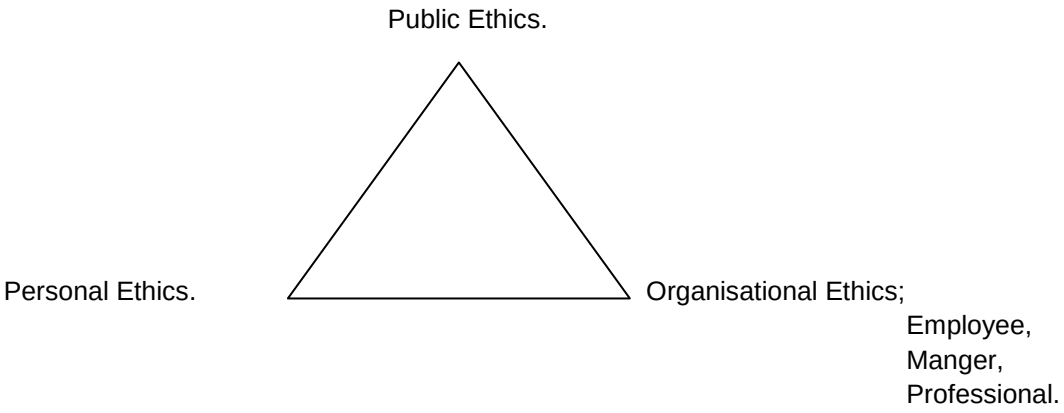
Perhaps one of the best examples of all of the old negative aspects of whistleblowing still being very much alive is that of Dr Nancy Olivieri who has insisted on publishing her adverse data on the drug Deferiprone which is for treating thalassemia. The drug company Apotex threatened her and the university, and the hospital put coercive pressures on her not to publish the data. Olivieri has been dismissed from her post within the hospital, and the drug company has been criticized for 'placing profits ahead of patient safety (Schafer 2007). As the case continues, all interested parties try to discredit each other in four books that have been written upon this case (Naimark et al

1998, Thompson et al 2001, Le Carre 2001, Schuchman 2005). In reviewing all of these cases, one gets a haunting perspective of the employee working within an organisation prior to a major incident. Some of the employees knew of dangers but kept silent, for example the Piper alpha disaster (Cullen 1990), the Clapham Junction rail disaster (Hidden 1989), and most recently in the case of Susan Hodges and Richard Murphy who are awaiting the outcome of an enquiry into the death of their baby son (Revill 2007). Some knew of dangers but kept quite for fear of retaliation. Others raised concerns which were dismissed or ignored, for example Paddington (Cullen 2000:3). A final group raised, and continues to raise their concerns regardless of the hostility and the prolonged nature of the whistleblowing, for example Graham Pink (Pink 1994), Dr Stephen Bolsin (Kennedy 2001), Bill Campell (Macalister 2006), Dr Nancy Olivieri (Schafer 2007). This raises the question 'What causes staff to function along this continuum of silence, to (prolonged) whistleblowing?', especially when they know to not speak out could have disastrous consequences.

Moral Framework

In attempting to analyse the answer to this complex situation, it would be useful to have a theoretical framework in order to develop a systematic response. Van Es and Smit (2003) provide one such theoretical framework which has three different domains for practical ethics. These are public, organisational, and personal ethics, with organisational containing the three roles of 'employee', 'manager' and 'professional' (Figure 10.)

Figure 10. Moral domains and perspectives. Adapted from Van Es and Smit (2003)



There is much debate regarding theories on moral reasoning, especially between Kohlberg (1975) and Gilligan (1998). Kohlberg (1975) defined six stages which were divided into three levels of preconventional, conventional, and postconventional moral reasoning, and thought that the majority of professional people responded to ethical dilemmas at the second level, which is characterized by conformity to majority behaviour. Most theorists agree that ethical behaviour follows a continuum of cognitive thought that progresses from narrow, self-serving view to a broader, more reflective view (McAlpine et al. 1997). On developing the 'Ethical Reasoning Tool' (McAlpine 1997) developed the responses into three levels. Level 1, Traditional response, is where responses focused on obedience to others; Level 2, Traditional/reflective response is where responses remained within traditional boundaries, but demonstrated an awareness of relevant ethical issues, and Level 3, Reflective response, where the responses were client centred, supported by an ethical framework, and demonstrated a willingness to challenge unethical practices.

Themes in the Literature

With the use of the combined frameworks of Van Es and Smit (2001) and McAlpine (1997), a number of themes can be identified in the literature on what influences individuals decision to remain silent, or to blow the whistle (Please see Appendix 2).

Personal Ethics

There is a lack of research in this area, and empirical studies that take a questionnaire survey approach can have a low response rate. For example Ahern and McDonalds' (2002) study achieved a 20% return rate. The other studies are individual case studies, or offer legal advice.

One of the major themes in the literature, disaster reports, and the press, is the negative consequences of whistleblowing to the individual. This is not just an historical perspective, but continues today as whistle blowers such as Bolsin and Olivieri write in the press. Whistleblowers are described, and describe themselves as 'fearing reprisals (Gobert and Punch 2000, Firth-Cozens et al. 2003), fearing retaliation (Yamey 2000), being demoted (Baty 2006), having their mental stability questioned (Schafer 2007), and losing their employment (Vickers 1999). This history would become known to any would-be whistleblower as it is in the culture of organisations, and well documented. It is worth noting that it is the same fear which causes an under-reporting of error (Leape et al 1991, Vincent 1999, 2001), and makes the role of Patient advocate so challenging (Chafey et al 1998, Watt 1997). A tension exists here regarding loyalty to self (integrity), patient, colleagues, and employer. The tension also goes against the powerful processes of socialisation and enculturation. Most of these cases will present

as a moral dilemma, where ‘there must be at the very least two courses of action which each have a claim to be obligatory, yet which cannot both be taken in the circumstances (McConnell 2006). Here the individual has to consider the cost of whistleblowing to all involved, with particular attention to the fact that it goes against the organizational cultures, professional codes of conduct which have an emphasis on team working and collegiality, and the dynamics of institutional loyalty. Rennie and Crosby found that the number of medical students prepared to whistle blow declined in the later year groups of the course, and goes on to propose ‘this may be on account of a strengthening of collective identity’ (Rennie and Crosby 2002:177).

In the health professions and in teaching, where the therapeutic-self is used in the caring act, this moral cost is significant and should be considered along with the literature on Emotional Intelligence (McQueen 2004, Schutte et al 2001). The professional codes conflict on where your duty lies, and they tend to ignore the duty to self as outlined in Kants Categorical Imperative upon which the codes are founded. With a consequentialist approach such as Utilitarianism often the interests of a single person is traded-off against common good. In both situations the individual can experience what Greenspan (1995) terms ‘moral cost’ or ‘moral remainder’. Greenspan also emphasis the role of emotion in decision making where he explains that dilemmas are a consequence of a set of social rules, when they prohibit action either way, emotion is ‘a second-best substitute for action’.

This psychological impact of whistle blowing is clearly evident in the literature where individuals report distress, isolation, economic and emotional deprivation, stress related

emotional problems, and being ostracized (Hunt and Shailer 1995, Vinten 1994, Dyer 1999a, 1999b, McDonald and Ahern 2000, CHI 2000). McDonald and Ahern (2000) make a clear distinction between 'isolation' where individuals are moved away from an area, that is away from known supporters' and 'Social ostracism' where the supporters are (emotionally) removed. Chiu found whistleblowers,

> …believe in the importance of protecting wider interests, are less concerned with self-interest, have a strong sense of self-efficacy and locus of control, and a higher than average need to control their environment (Chiu 2003:585).

This widening gap between personal values and the employing institutions values will be discussed below under 'Organisational Ethics'.

Organisational Ethics

There are a number of factors which have influenced the ethics of the National Health Service, probably the greatest being the introduction of competitive tendering when NHS Trusts became exposed to global market forces (Chaston 1994, Brereton 2010). Specifically, the three principles of Neoliberalism has had a great impact upon the organizational ethics of the Health Service in, principally the United Kingdom, but also in Canada, Unites States of America, Australia, and New Zealand.

Where previously Keynesian economics has encouraged cooperative working within the Health service, Neoliberalism emphasised Individualism, the Free Market, and Decentralisation. There are a number of (ethical) internal conflicts with Neoliberalism

when applied to the Health Service: 1. The greatest user group within the Health Service are those from poorer socioeconomic backgrounds. The ethos of Health promotion / prevention is to target this group as it has an economic impact upon the country and world. Advocates of neoliberalism believe in pressuring the poorest people in a society to find their own solutions to their lack of health care. This does not consider the greater or collective good, and this is a significant point as A.I.D.S., T.B., and many other diseases are not respecters of class or creed; 2. The pursuit of narrow self-interest rather than mutual interest is in stark contrast to the higher level required in Moral Theory as espoused by, for example Levinas, which puts the other first.. In other words, most theorists agree that ethical behaviour follows a continuum of cognitive thought that progresses from narrow, self-serving view to a broader, more reflective view (McAlpine et al. 1997);3. Finally, the starting point for any ethical behaviour is that the individual actually cares about the other and has a sensitivity to the most vulnerable, and yet according to McGregor a

> …basic assumption of neoliberalism is that human beings will always try to favour themselves. As they do this, they need have no concern for others or the environment. This absence of concern can exist because each person is assumed to act independently of others and is assumed to be restricted only by his/her natural surroundings and NOT by any other human being (McGregor 2001: 84).

Another major theme within the literature is that whistleblowers feel that they are not listened to within their own organizations (Treasure 1998, Irving et al 1998, Moore et al. 2010). Graham Pink (1994) spent two years raising his concerns in 43 letters. Dr Bolsin raised his concerns on eight critical occasions (Dehn 2001). Along with this

feeling was the thought that nothing would be done even if they did raise concerns (Hunt and Shailer 1995, Davidson 1998, CHI 2000). These features of organisational ethics are useful as indicators of espoused values. Even once investigations into negligence had commenced there was a culture of secrecy within the health service. Ritchie (2000) found 'considerable reluctance' amongst nursing staff to cooperate with her Inquiry into Rodney Ledward. Some nurses refused to attend to it at all, and one who did was told by another nurse 'more the fool you'. Vickers (2001) argues that the Public Interest Disclosure Act (1998) may be limited in helping staff to speak out. The reason for this is that any disclosure must be made in 'good faith', where it would be very easy to attribute mixed motives to any potential whistleblower, which would prevent protection under this section.

Public Ethics

Globally, the approach and attitude towards ethics is changing. There is also greater access to quality research in a timelier manner. In his book on a moral history of the twentieth century Glover (2001) brings out this point where he states '…I was struck by the range of experience that he and other Polish philosophers could bring to thinking about ethics, and also by the way much English-language writing on ethics is limited by relative insulation from some of the twentieth century's man-made disasters'. Many of these changes are due to the result of major political reform. Of special interest are the social anthropology studies on the demise of socialist power in Eastern Europe and the Soviet Union. An example of this would be those carried out by the Max Plank institute for social anthropology (Hann 2005). This changing socio-political spectrum offers an opportunity to study this emerging situation and to consider the moral effects

of different regimes. Morality and economic success do seem to be related in the current literature on the removal of socialist power in the Soviet Union (Hann 2005). Pokrouvskii (2001) focuses this point further in her question ‘Does moral progress parallel economic growth? Alternatively, is there perhaps a reverse relation?’. Neuberger (2005) takes a similar analysis from the British situation in her book *The Moral State We’re In*. The ideologies of Socialism in Eastern Europe and the Soviet Union, and Communism in China provide a model for research, especially now that these political systems have been replaced. Chiu (2003) outlines some of the behavioural changes in the transition from planned to market economies, from a situation of high external control, to one based upon Market forces. The literature on whistle blowing, and the government inquiries on disasters undermined the Publics’ confidence in the ability of corporations and professions being able to regulate themselves. With this lack of trust came the introduction of a whole raft of new legislation including the re-writing of professional codes, the introduction of the charity Public Concern at Work, the passing of the Public Interest Disclosure Act. Some detailed examples of this external regulation are the GMC introduced a clause into the ‘Duties of a Doctor’ which places a professional responsibility on doctors to report a colleague suspected of being unfit to practice (GMC 2009a), One of the recommendations in the Bristol Inquiry was for hospitals to publish mortality league tables (Blumenthal (1996), the Commission for Health Improvement (CHI) was introduced to inspect hospitals, and the UK Consensus Statement on undergraduate teaching of medical ethics and law, recommends whistle blowing as a core curricular topic (Consensus Statement 1998).

Conclusion

Undermining the quality control mechanisms within organisations seems to be a consequentialist calculation of costs and benefits. As already discussed, a number of organisations chose to ignore the recommendations made in reports which had serious safety implications. While a number of processes have been put in place to encourage and support whistle blowers, the most recent research demonstrates it still has all of the high cost implications to the individual. Even the introduction of whistle blowing into the curriculum appears to have the opposite effect to that intended in that medical students are less inclined to whistle blow the longer they remain a student (Rennie & Crosby 2002). The overall conclusion would be that there is a power relationship between the individual, the individual as part of a team, the organisation, and the process of enculturation which suggests relational ethics plays a more functional role than external legislation.

CHAPTER FIVE: FREE TO BE CONDEMNED?[64]

> Thus ethics is no longer a simple moralism of rules which decree what is virtuous. It is the original awakening of an I responsible for the other: the accession of my person to the uniqueness of the I called and elected to responsibly, which is the true beginning of the human and of spirituality. In the call which the face of the other addresses to me, I grasp in an immediate fashion the graces of love: spirituality, the lived experience of authentic humanity (Levinas 2001:182).

Introduction

Chapter Four (Ethical Decision Making) traced moral behaviour through the process of decision making. It explored the complex processes of decision making within the multidisciplinary healthcare team, from how it is taught within the healthcare curricula, how health professionals make decisions, through to the contextual dynamics situated within the health care system. Chapter Four (Whistleblowing) explored how professionals raise concerns regarding poor clinical practice, and finally discussed the role of the National Health Service Litigation Authority (NHSLA) in addressing issues of an ethical nature.

Chapter Four concluded by identifying Deontology as the main philosophy underpinning regulatory codes of practice, and the concept of a 'duty of care' owed to patients. It discussed virtue ethics in relation to the process of enculturation through clinical practice, and also considered the undermining dynamic of a utilitarian, consequentialist calculation of cost and benefit. The overall conclusion was that there is

[64] Adapted from Jean-Paul Sartre, *Existentialism And Humanism* (Sartre 1973:34) 'We are left alone, without excuse. That is what I mean when I say that man is condemned to be free'.

a power relationship between the individual, the individual as part of a team, the organisation, and the process of enculturation which seems to suggest relational ethics plays a more functional role than external legislation in providing sensitive, ethical care to patients.

The theoretical analysis performed in the previous two chapters has identified the two concepts of *freedom* and *movement.* The latter only in passing-this has yet to be explained, but will be here as crucial in providing ethical care to patients. This chapter and the following are an invitation to consider these two concepts from a range of philosophical perspectives. Where Chapter Five focuses on critically analysing these concepts within the legal and political processes, Chapter Six follows the same analytical discourse in questioning whether ethics is prior to ontology.

The main goal of this chapter is to move the discussion into the legal framework influencing clinical practice, and the wider political context of health care. In order to achieve this goal, this chapter is divided into the following sections:

1. Hermeneutics and the decision making process in law
2. Hermeneutics and the political context of health care
3. Caring as Commerce
4. Defining responsibility in law-the ‘Duty of Care’ concept
5. Conclusion

Section One outlines the legal procedure in cases of clinical negligence, and discusses the specific method taken in Case law termed the Black Letter approach. The discussion develops to include jurist's decision making and Kants' work on judgment. With the legal process established in section one, section two then expands the analysis to consider the political context of health care. Section three explores responsibility to others from a legal perspective and from Levinas' concept of *Face.*

The overarching analytical framework being applied to this chapter and Chapter Six is the philosophical category of movement which is based upon the work of Aristotle and Kierkegaard. Additionally, theories of justice will be considered principally to distinguish the extent of the connection between law and morals in the five selected legal cases of clinical negligence. The concept of movement will be introduced first, before providing an overview of the main theories of justice.

Aristotle defines the *kinesis-energeia* dichotomy in the *Metaphysics* (1924), and then develops this in the *Physics* (1936). Where Aristotle was focusing on this dynamic structure of being within the universe, Kierkegaard applied these concepts to human actions (Stack 1974). Carlisle provides a helpful distinction between the concepts *dunamis* (potentiality) and *energeia* (actuality) by providing the example that a seed is ''potentially' what the mature plant is 'actually' (Carlisle 2005:12)'.She then concludes 'Kinesis is, then, a category of transition, and it signifies a process of actualization (Carlisle 2005:12)'. It is then, this category of kinesis which will be explored in this chapter and Chapter Six.

One of the sustained debates within jurisprudence which is relevant to this study, concerns the extent to which morality pervades law. Legal theorists have debated three main views on the relationship between legal and moral theory (Wacks 2005).Legal positivism which has been developed from Bentham and Hume, considers law as consisting of 'Posited' rules, and as such is morally neutral (Wacks 2006). Hart is one of the most influential writers within legal positivism. His conception of law was as a social phenomenon that could only be understood by describing the actual social practices of a community (Hart 1997). The second main legal theory views legal reasoning as identical with moral reasoning, and is termed Natural law. The essence of natural law is that there are objective moral principles which depend upon the nature of the universe and which can be discovered by reason (Freeman 2001). While Legal positivism and Natural law provide a contrasting view, they both however subscribe to the view that 'there is no prima facie moral obligation to obey an unjust law (Wacks 2005:151)'. The dominant pervading theory of positivism has been greatly challenged over the past thirty years by Ronald Dworkin (Wacks 2005). Dworkin views law as 'Interpretive', where legal reasoning aims to reformulate past legal decisions in the most coherent and morally attractive way. In order to keep the discussion focussed upon kinesis it appears significant that Dworkin includes in his explanation of interpretation;

> Each judge's interpretive theories are grounded in his own convictions about the "point"-the justifying purpose or goal or principle-of legal practice as a whole, and these convictions will inevitably be different, at least in detail, from those of other judges (Dworkin 2006:88).

From this it seems crucial that the judge has chosen the ethical way of being, especially when reflective judgement plays such a significant role as opposed to determinant judgement. If, in contrast to Dworkin's proposal, judges took more of a positive approach, which would be akin to Kant's 'determinant judgement' there would be less reliance upon the individual judge's thoughts, values and opinions. This will be discussed later in relation to Kant's work on determinant judgement (where the case is brought under a pre-existing rule) and reflective judgement (searching for a rule/concept that fits the particular case). Reflective judgement thereby has a reliance upon the individual choosing the ethical way of being, that is not necessary in the same degree in determinant judgement.

This is a kinesis from non-being to being. For Levinas '…the original awakening of an I responsible for the other (Levinas 2001:182)'. Kierkegaard emphasises the importance of freedom and action in the ethical stage as opposed to the distracted way of being in the aesthetic sphere:

> …ethics, which does not have the medium of *being* but of *becoming* and therefore denounces every explanation of becoming that deceitfully wants to explain becoming within being, whereby the absolute decision of becoming is essentially revoked and all talk about it is essentially a false alarm[65] (Kierkegaard 1992a:421)

Kinesis then sets up a dialectic of movement and change that occurs within the individual. It provides a conceptual framework from which to explore this tension between non-being and being of the individual in a totalising system. The concept will

[65] All emphasis is in the original.

be considered below in relation to the legal system to consider the extent that individuals have made this transition. In Chapter Seven the freedom to act is explored as a series of *aporiai*[66]. In Chapter Eight it will be applied to the tension between movement and knowledge where *repetition* is considered in contributing to epistemology. First, then, kinesis will be reviewed in the judge's freedom to be ethical.

In this chapter, the concept of justice is examined in relation to the potential duality of the ontological and ethical subjectivity. The theoretical analysis on conceptions of justice will draw upon a number of philosophers in exploring questions of justice as being, and also as an ethical event. Some of the main tensions to be examined appear to be set out by Levinas where he said;

> We are we because, commanding from identity to identity, we are disengaged from the totality and from history. But we are *we*[67] in that we command each other to a work through which we recognise each other. To be disengaged from the totality while at the same time accomplishing a work in it is not to stand against the totality, but for it - that is, in its service. To serve the totality is to fight for justice. The totality is constituted by violence and corruption. The work consists in introducing equality into a world turned over to the interplay and the mortal strife of freedoms. Justice can have no other object than economic equality. It is not born of the playing out of injustice itself - it comes from outside. But it is illusion or hypocrisy to assume that, while born outside of economic relations, justice can be maintained outside, in the kingdom of pure respect (Levinas 2006a:31).

[66] The concept of *aporia* is founded upon the Greek language, with the prefix *a* meaning 'without', and *poros* denoting 'path or passage' (Mautner 1999:32) . *Aporia* is variously translated as; no passage, or as an impasse. Aporia is the singular, with *Aporiai* being the plural form.
[67] Emphasis in the original.

The importance of this disengagement from the totality and history is a theme which will be developed throughout the thesis. First, the legal process will be discussed in relation to how cases of clinical negligence are considered.

1. Hermeneutics and the Decision Making Process in Law

One approach to decision making used in law, religion and ethics is hermeneutics. The background to this method is important within healthcare ethics and law since professionals draw guidance from legal (statutes, precedents, and treaties), religious, and classical texts, and yet there is a challenge with how this text is applied. Schmidt summarises this challenge where he notes:

> Understanding occurs as a fusion of the so-called past horizon of the text with the present horizon of the one who understands. The central problem of hermeneutics, the necessary task of application, concerns how the text is brought to speak in the interpreter's now expanded horizon (Schmidt 2006: 8).

The two words 'Hermeneutics' and 'Exegesis' both mean to 'interpret'. Hermeneutics from the Greek word *herměneuein*, and 'Exegesis' from *ex* 'out of' and *hegeisthai* 'to guide, or lead' (Mautner 1999). Inwood, adds richness to this background by stating that both of these Greek words are derived from the name Hermes, the messenger of the Greek gods, and that *hermēneutike (technē)* is the 'art of interpretation' (Inwood 1995: 353). Hermeneutics has also developed from a narrow definition as outlined by

Schleiermacher (1998) which was applied to texts, to a broader definition as in Heidegger (1999) which he applied to *Dasein*[68].

Interpreting Common law takes an exact approach termed 'Black-letter'. The black-letter approach provides an exact method for understanding law as a practiced system and a recognised legal framework for interpreting Case law. Balkan describes the black-letter approach as 'through the lens of a specific interpretative framework (Balkan 1996: 956)'. This framework involves seeing each case as if it formed part of a system of rules which are internally connected and related to each other in distinct clusters and groups (Hofheinz 1997). Such rules are embedded in other legal Cases and in Statutes with the internal connections being identified through cross-referencing specific rules, and through the identification of legal principles and axioms. A philosophically significant point is that within this approach the analysis must 'insulate' the topic from supposedly 'non-legal factors' which would include policy, political, social and economic issues as though these were somehow 'external' to legal research (Hofheinz 1997).

This method has been applied in all of the cases researched and an overview of the process is best seen in Appendix 2 where the main statue law, and 'significant cases' are referenced for each transcript. Legal authority is found by paying particular attention to the most recent appeal judgments regarding the case in, for example, the Court of Appeal, House of Lords, and the European Court of Justice. Twining (1994)

[68] For Heidegger, *Dasein* is an active living of life. It belongs only to those entities whose being is 'an issue' for them.

helpfully explains that disputed points of law largely dominate the lower level courts, and that points of law prioritised by the black-letter tradition are mainly found in superior courts. Within legal reasoning ‘Cases’ are located at the base of a hierarchical pyramid with legal rules, legal principles and axioms being prioritised in turn above this. As a system it would now be worthwhile to explore how the Black-letter approach within law articulates with the philosophy of Hermeneutics.

Insulating non-legal factors occurs in two main ways within the legal system. Firstly, by the hierarchical structure of the court system. That is, in cases of clinical negligence, the main clinical details are gathered in the court of first hearing. This is why so many jurists are reluctant to question this process, as they argue that the judge within the court of first hearing has had the privilege of seeing the witnesses face to face. Jurists in higher courts have to depend upon the clinical evidence gathered in the first court. The only additional clinical detail which may be requested at a later date is that provided by a clinical expert.

In addition to this process, clinical details are isolated via the Black–letter approach, where once gathered, they contribute to the legal argument, and the technical definition of the case. For example most of the cases reviewed have been defined as within the Tort of negligence. In such cases the Claimant (Plaintiff in Scotland) must prove that there was a ‘Duty of care’ owed to the claimant, that this duty was breached, and the negligence caused harm. By this process there is a rapid progression from what could be termed ‘clinical language’ into the technical language of law.

The Black-letter system tries to separate 'non-legal factors' and legal factors. In this process some of the clinical details have been handled with a lack of due concern and not given the significance which they would be given in professional clinical practice. At times they have been interpreted incorrectly. This occurs at the court of first hearing, but can also be demonstrated as a weakness within the decision making process within the House of Lords.

The legal decision making process can clearly be seen in all of the cases where the relevant Statute law is applied, relevant Cases identified, and the *ratio decidendi* (reason for deciding) adhered to. The *ratio* of the case has to be decided from its facts, the reasons the court gave for reaching its decision, and the decision itself. Only the *ratio* of a case is binding on inferior courts, by reason of the doctrine of precedent (Martin & Law 2006). However, it is confusing to see precedent applied in what seems contradictory ways. Some of the most significant cases being in the House of Lords where each law lord provides the rationale (including references) for their judgment. In these rulings the judgments are sometimes as close as 3; 2 dissenting[69]. From this situation the question arises of how such disparate judgments occur when such a rigorous legal process is followed.

Although the current discussion relates to law, the same interpretative challenges apply in world religions and healthcare ethics. In a recent symposium on 'Religions and Cultures of East and West; Perspectives on Bioethics' ethicists were invited to discuss

[69] Please see Appendix 2. Table 1 & 2 provide the detail of the jurists' decisions, which is a similar process to that outlined by Zoloth (2008).

the influence of their own religion and culture when considering issues within bioethics (Sade 2008). The research papers consider such views from the Jewish (Zoloth 2008), Chinese (Kirkland 2008), Christian (Lustig 2008), Hindu (Sarma 2008), Islamic (Athar 2008), and Japanese perspectives (LaFleur 2008). One of the key features for the ethicists is in interpreting classical texts in the current context. For example, Zoloth when considering Judaism explains:

> Hence, the casuistry that supports ethical response is based on exegetical reasoning that is debated over a prolonged temporal period. New developments in the field of molecular biology, however, call for innovations within this tradition, and they call for them very rapidly (Zoloth 2008: 14).

In a similar way with the black letter approach within law, it is sometimes difficult to find a Case which is a good fit for the legal problem, or a similar relevant religious/classical text. Zoloth goes on to identify some of the hermeneutic challenges within the Jewish tradition:

> Jewish ethics is essentially a complex, reasoned argument about how such Biblical texts, historical and contextual judgments, and an interpretive community's normative values are brought to bear on a particular case at hand (Zoloth 2008: 15).

This is strikingly similar to Dworkins view of law where he writes:

> Law as integrity asks a judge deciding a common-law case like *McLoughlin* to think of himself as an author in the chain of common law. He knows that other judges have decided cases that, although not exactly like this case, deal with related problems; he must think of their decisions as part of a

> long story he must interpret and then continue, according to his own judgment of how to make the developing story as good as it can be (Of course the best story for him means best from the standpoint of political morality, not aesthetics) (Dworkin 2006: 238 & 239).

In Schleiermacher's universal hermeneutics, he distinguishes between two parts to the art of understanding: the grammatical, and the psychological.[70] Both are interdependent, however, and the interpreter must decide upon which emphasis to give to each, depending upon their area of work (for example, law, theology, or classical literature). The next challenge for the interpreter is breaking in to the topic, at the textual level it is about understanding words within sentences, and sentences within a text. At a more general level it concerns the authors work as a part in relation to the whole of his culture, and this culture as embedded in the history of an era. There is an interdependence of whole and part which is defined as the 'hermeneutic circle'. At the existential level this includes the individual meaning of a person and of their particularities in relation to the concept of a human being (Schleiermacher 1998).

In the current analysis of the case transcripts, this is a challenging area for jurists because they have to understand clinical language, and the letter of the law. Schleiermacher explains:

> Everything in a given utterance which requires a more precise determination may only be determined from the language area which is common to the author and his original audience (Schleiermacher 1998: 30).

[70] Both Schleiermacher and Dilthey develop their theories upon Kant's *Critique of Pure Reason.*

Heidegger expands upon Schleiermachers's definition of hermeneutics to apply not just to texts, but also to other aspects of human being where he states; 'Hermeneutics is the announcement and making known of the being of a being in its being in relation to me (Heidegger 1999: 7)'. This challenging aspect of interpretation can perhaps be best seen within law, in the role of the 'Expert Witness'.

Precisely because the legal system recognizes the inherent problems in trying to understand a language area 'Which is common to the author and his original audience' (Schleiermacher 1998:30)**,** the justice system is dependant upon Expert Witnesses. As a consequence of this both defendants and the legal system itself are vulnerable to experts who lack integrity and or skill (Dwyer 2008).

Following the Bristol Royal Infirmary inquiry Kennedy reported that the current Tort based adversarial system of negligence liability supports a culture of blame and fear, encourages a code of silence amongst professionals, and results in errors being covered up (Kennedy 2001: paragraph 26.). Since then the department of health in England has consulted with health professionals regarding the options for the future of clinical negligence litigation within the NHS. In 2003 Sir Liam Donaldson (Donaldson 2003) authored a report on 'Making Amends - A Consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS'.

The role of the Expert Witness is in assisting the court to ascertain the true facts. In a lecture given by Sir Anthony Clarke he explains:

> My experience of various types of litigation and arbitration over many years has convinced me (as is perhaps self-evident) that the expert plays a crucial [role] in the administration of justice, both civil and criminal. Without the expert witness it would be almost impossible for judges to decide very many types of case (Clarke.2008: 85).

Most of the legal cases analysed, and indeed most of the healthcare cases are classed as 'complex'. Bloom-Cooper emphasizes this challenge for jurists where he expounds:

> There are times-especially in the world of high technology with society's growing appetite for dispute resolution in the courts-when the ability of judges [and I would add juries] to understand the true import of expert evidence and reach an informed and well-reasoned judgment will be taxed to the utmost, and even beyond judicial endeavour (Bloom-Cooper 2006:7).

In order for justice to be carried out for the claimant and defendant, the expert must be free to give unbiased opinion. For the courts to provide justice it has to carry out the two functions of, firstly establishing the true facts, and with this done, it must then apply the relevant principles of law to those facts, 'to provide a judgment, which is both correct in fact and law (Clarke 2008: 85)'. From this it can be seen that the 'facts' and 'rules' are separated. That there is what may be called the 'clinical language', and 'legal language'. That the judge is dependant upon the Expert Witness, and yet once the clinical information is gathered it is isolated through the Black-letter approach. It appears to be reasoning which involves both *a priori* and *a posteriori*, but the legal process gives precedent through *a priori* knowledge.

The judiciary go to a great deal of effort in trying to establish the objective truth. As discussed in chapter 2 (2.2 Legal Analysis), and in less detail above, the legal process is an evolving approach which stringently applies legal axioms, and legal precedent in an attempt to try and find the objective truth for all concerned in the case. Yet, the experience of the legal process is different from the various perspectives of patient, nurse, doctor, manager, and the hospital executive team. One of the main differences is that it is usually the patient, or a relative of the patient, who has experienced first-hand the alleged clinical negligence. This perspective will now be considered in the light of Kant's transcendental metaphysics, and in his ethical theory.

Kant attempted to show that traditional metaphysics rests upon a fundamental mistake when it presupposes that we can make substantive knowledge claims about the world independently of experience (Kuehn 1999). It is this discussion on the role of experience in establishing objective knowledge which appears to be relevant to the cases of clinical negligence. Perhaps the problem is stated best by Ewing where it is explained; 'For the main question always is - what and how much can understanding and reason come to know without the help of any experience…?' (Ewing 1923: xi).

Kant wrote three critiques; The first, *Critique Of Pure Reason* in 1787, then the *Critique of practical reason* in 1788, and finally the third, *Critique Of Judgement* in 1790. While the above question is answered in the first critique, Kants' third critique will be called upon in considering the pleasure aspect of making a judgement. Additionally, the *Critique Of Practical Reason, Groundwork Of The Metaphysic Of Morals* 1785, and *The Metaphysics Of Morals* 1797 will also be consulted on issues of

a wider ethical nature. In the *Critique of Pure Reason*, Kant (2007) distinguishes between three powers of the mind. These are the abilities to sense, to understand, and to reason. Kant's philosophy develops through the three *Critiques*. In the *Critique of Pure Reason,* to judge was to apply a concept or rule to particulars (Schaper 2006:369). In the third critique (*Critique of Judgement*) Kant wants to call that kind of judgement 'determinant' judgement and to distinguish it from 'reflective' judgement, where the particular is given and the rule or concept under which it falls has to be found or discovered (Schaper 2006:369).

With this distinction at the forefront, Kants' critical philosophy tries to show what is involved in making a judgment. The structure outlined is that we have the ability to register sensory data such as sensations which he termed 'sensibility'. Next we have intellect. This is the 'understanding'. The final faculty is 'reasoning' which is the ability to infer logically. In the introduction to the final Critique Kant explains that "Judgment" takes the middle position between "understanding" and "reason" (Schaper 2006).

Within the legal Case transcripts non-legal factors are isolated. The receptivity to such sensory information, Kant termed 'intuitions', and he categorically denies that we can have any knowledge which is purely conceptual. Kant outlined the importance of a *synthesis* between these faculties in the *Critique of Pure Reason* where he proposes:

> Our nature is so constituted that our *intuition* can never be other than sensible; that is, it contains only the mode in which we are affected by objects. The faculty, on the other hand, which enables us

> to *think* the object of sensible intuition is the understanding. To neither of these powers may a preference be given over the other. Without sensibility no object would be given to us, without understanding no object would be thought. Thoughts without content are empty, intuitions without concepts are blind. It is, therefore, just as necessary to make our concepts sensible, that is, to add the object to them in intuition, as to make our intuitions intelligible, that is, to bring them under concepts. These two powers or capacities cannot exchange their functions. The understanding can intuit nothing, the senses can think nothing. Only through their union can knowledge arise (Kant 2007:93).

Yet as a system the law appears to drive a wedge between 'intuitions'- as clinical detail on the one hand, and understanding and reasoning as legal concepts, on the other. It is important to highlight here that the clinical details are only structurally similar to intuitions. The reason for this is that clinical details are not just undetermined sensations; rather they are already determined by concepts as particular kinds of objects such as clinical signs and symptoms[71]. The crucial point is that the judges would need to know these concepts in order to recognise the order of importance upon clinical information. It does not seem to be the case that the law ignores 'intuitions', for in the area of the Expert Witness the legal system is in a dependant situation, with bias resulting from this. It seems rather that by attempting to bracket and control the 'intuitions' thereby disunion occurs.

Crucial to this discussion is the conceptual structure within which all thought and experience is thought to take place. In an eloquent section where Kant is discussing the frustration within Metaphysics, he explains; 'Ever and again we have to retrace our

[71] I would like to acknowledge the insightful help of Dr Rachel Jones, philosophy department, University of Dundee, with this section.

steps[…] (Kant 2007: 21)', and, '[…] the procedure of metaphysics has hitherto been a merely random groping, and worst of all, a groping among mere concepts (Kant 2007: 21)'. In response to this question:

> Why, in that case, should nature have visited our reason with the restless endeavor whereby it is ever searching for such a path, as if this were one of its most important concerns? (Kant 2007:21).

Kant proposes what he called his 'Copernican Revolution';

> Hitherto it has been assumed that all our knowledge must conform to objects. But all attempts to extend our knowledge of objects by establishing something in regard to them *a priori*, by means of concepts, have, on this assumption, ended in failure. We must therefore make trail whether we may not have more success in the tasks of metaphysics, if we suppose that objects must conform to our knowledge. This would agree better with what is desired, namely, that it should be possible to have knowledge of objects *a priori*, determining something in regard to them prior to their being given (Kant 2007:22).

It is from this position of objects conforming to our knowledge that difficulties appear to arise within the legal system. For Kant, a judgment involves a synthesis of concept and intuition. For this transcendental synthesis to occur the understanding must draw upon *a priori* concepts which he termed 'categories[72]'. Although the categories are applied by principles, the categories relate to all understanding. Kant repeatedly stated that this theory of understanding '[…] is not to be construed as empirical psychology'

72 Kant defines twelve 'categories'. Some of the main ones are; Totality, Unity, Negation, Reality, Possibility, Existence and Causality.

(Scruton 1987: 22). It may be at this stage worthwhile to make a trial of this framework contained within the Transcendental Analytic in relation to the legal transcripts.

From Kant's perspective, any patient (or judge) will be presented with many different sensations which he termed a 'manifold of intuitions'. Crucially, the way in which the patient will sift or gather this selection of intuitions together and identify connections Kant called 'synthesis'. According to Kant, it is here that the source of knowledge arises; 'It is to synthesis, therefore, that we must first direct our attention, if we would determine the first origin of our knowledge' (Kant 2007:111&112). This synthesis has two aspects to it which has real consequences to the way a patient's care experience is viewed by judges[73]. Firstly, Kant considered self-consciousness as a prerequisite for synthesis to occur, and that the 'I think' does not always accompany the perceptions for every being. Consequently, the patient or judge would not know their own experience. Kant explained this relationship where he said 'All the manifold of intuition has, therefore, a necessary relation to the 'I think' in the same subject in which this manifold is found' (Kant 2007: 153). The second aspect is where the synthesis involves the active application of a concept. Although Kant identified specific 'categories', the individual still has to recognise the familiar concepts within their sphere of existence. Where David Bell (2003) provides the helpful example of the manifold sensations which would help him identify his motorbike, the same would apply for the patient recognising pain, the nurse recognising a rapid pulse rate, and the judge recognising

[73] While the example here is regarding patients, it is recognised that Kant intended this synthesis as 'transcendental' and not merely as a psychological fact.

clinical negligence. Where the potential challenge appears to arise is recognising the concepts in an unfamiliar conceptual terrain.

This situation is challenging at all levels of judgement. That is from the patient, health care staff, NHS managers, and for jurists. Kant's distinction between 'determinant' and 'reflective' judgement provides some helpful insight into some of the complexity of such reasoning. Applying a concept or rule to particulars ('determinant' judgement) appears to be uncommon for jurists in the 'hard cases' reviewed so far. Rather, it appears as if the jurists are being presented with the particular and they have to find the rule or concept under which it falls ('reflective' judgement). Such a view would be sympathetic to Dworkins' view of law as being 'Interpretive' where legal reasoning aims to reformulate past legal decisions (Dworkin 2006). However, it would still fail to explain how such disparate judgements occur when jurists follow such a precise, rigorous legal process.

It is precisely at this juncture that Kant's work in the *Critique of Judgement* is helpful in exploring things where their possibility can be explained neither by the objective principles of the pure understanding or by the moral law.

The Moral Law for Kant includes the following practical imperative;

> Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end (Kant 1997a: 91).

The following discussion aims to consider precisely this 'means-ends' in relation to reflective judgement. Whilst this discussion will focus on the judgements made primarily by jurists, this analysis encompasses all judgments, including those made by health care staff and managers.

Kant sets out an explanation of reflective judgement in Introduction IV (On Judgement as a Power That Legislates A Priori) of the *Critique of Judgement* (1987). In the introduction Kant provides the limits of Determinative judgment which is 'subsumptive' (Kant 1987:19). Following this Kant identifies the precise area where determinative judgement runs out:

> On the other hand, since the laws that pure understanding gives a priori concern only the possibility of a nature as such (as object sense), there are such diverse forms of nature, so many modifications as it were of the universal transcendental concepts of nature, which are left undetermined by these laws, that surely there must be laws for these forms too (Kant 1987: 19).

As reflective judgement moves from the given particular to the universal, this also requires a principle, and Kant postulates that reflective judgement gives this law 'but only to itself (Kant 1987:19)'. This principle is a key which opens up a number of teleological vistas;

> Now insofar as the concept of an object also contains the basis for the object's actuality, the concept is called the thing's *purpose*, and a thing's harmony with that character of things which is possible only through purposes is called the *purposiveness* of its form (Kant 1987: 20).

This teleological and aesthetic view involves considering objects - whether as law making or patients - as hypothetically as purposive and as products of intentional actions (Shaper 2006). This thesis has great potential in considering the purpose of laws or indeed patients as such judgements '…are mainly used when there is a relation between a cause and effect which a person intends (Fricke 1990:48)'. For example, this helps to explain Dworkins view that;

> Each judge's interpretive theories are grounded in his own convictions about the "point"-the justifying purpose or goal or principle-of legal practice as a whole, and these convictions will inevitably be different, at least in detail, from those of other judges (Dworkin 2006:88).

From Kant's thesis it can be seen that what sets the judgement of taste apart from other kinds of judgement is that the feeling of pleasure alone determines it. Schaper (2006: 371) confirms this where she emphasises:

> The most subjective and private of human capacities, that of feeling, far from being mute and inchoate, could, Kant now thought, yield the determining ground of the aesthetic judgement (Schaper 2006:371).

This has real consequences for jurists as law makers and in considering the teleological perspective of the case, especially when the *ratio* could potentially influence many future cases. It emphasises that the deontological principle is insufficient alone, but requires to be coupled with an ability for reflective judgement. Equally, it has real potential for the way in which patients are viewed, potentially as holistic individuals or more as commodities in a market economy where success is measured in terms of

waiting lists, and patient through-puts. These perspectives will be discussed in the next section on the political context of health care.

2. Hermeneutics and The Political Context of Health Care.

Discussion regarding this legal decision making process has to be set within the current political system. This is important within the NHS and the area of clinical negligence in terms of innovative new treatments and the financial cost of offering such treatments. Deakin et al. outlines this change where they state:

> Thus, the politicization of tort law is thus becoming obvious in our system as well as the patchy nature of our reforms clearly reflect either the impact that pressure groups have on the generation of 'partial' legislation or even the introduction of legislation which openly admits as its first objective the desire to save the NHS money (even if the long term effects of this reform remain openly uncertain) (Deakin et al. 2008: 8).

In fact, the legal area of clinical negligence is undergoing major reform. An estimate of the size of the problem can be seen in the National Audit Office statistics on the financial cost of negligence claims within the NHS. The NHS Litigation Authority, which handles out-of-court claims against the NHS in England, spent £530 million settling cases in 2004-2005, and has made provision of £7.6 billion for unsettled claims in 2004-2005 (Hall 2005). The reforms were set out in the chief medical officers consultation document 'Making Amends' (Donaldson 2003). The first recommendation of the document which was to introduce an NHS Redress Scheme without the need for court proceedings has now been introduced in the NHS Redress Bill (House of Lords.2005). It is significant to note that one of the principle aims of the reforms as

identified to the independent charity, Action Against Medical Accidents (AvMA), and as identified in the research commissioned for ‘Making Amends’ was; ‘preventing the same thing happening to someone else (Walsh 2005:267).

The reason for detailing the legal procedure to identify if a duty is owed to the Other, is to make this clear before setting it into its political context. The relationship of responsibility to the Other will be explored next in a political context. Consideration will be given to whether the limits of this relationship are largely dependant upon economic ends.

One of the major influences upon the delivery of care within the National Health Service was the exposure of the health system to market pressures. For the first time the NHS was planned to operate on market values, where previously it was traditionally governed by non-market norms (Sandel 2009a). Prior to 1991, the NHS had existed as a system for almost fifty years, where professional incomes had ceased to depend upon selling clinical process as a commodity (Hart 1995). In 1991, the United Kingdom government introduced a quasi market for the delivery of healthcare. This was similar in other parts of Europe, America, and in New Zealand (Laugesen 2005). In this quasi market paradigm, healthcare was set into an economic analysis. The manufacturers of goods –as health- (Hospitals, General Practitioners) were separated from the purchasers of goods. This ‘purchaser-provider’ split then inadvertently viewed patients as commodities. Part of this reform included a policy to develop an internal market, where there was provider competition. Creation of an internal market had an explicit aim of encouraging competitive markets. In this system hospitals were converted to Trusts,

and General Practitioners transformed into General Practice Fund Holders (GPFH) (Propper and Söderlund 1998). Providers then competed for patients not just in their regions but also in other regions. The end result was to put pressure on the quality adjusted unit costs for the health care required (Melinick et al. 1992).

Crucially, the NHS was (and remains) a 'quasi', or modified market. Crucially so in fact, because if it was a pure form market, discussions would eventually arise about the value (as price) of products. In Europe, the introduction of 'user fees' was less than what policy makers had proposed (Laugesen 2005). Precisely because the government intervenes in ensuring universal access to comprehensive care, determines health care need, and the ensuing resource allocation, two major consequences result from this regarding moral action.

Firstly, patients are denied the opportunity to choose within the market where they would like to receive their health care. In a pure market this would stimulate price reduction, or higher quality care at the same price. Importantly, it would define where patients as individuals placed value. Much of the NHS reforms were based upon the work of Professor Alain Enthoven who spent one month in the United Kingdom in 1984 reviewing the NHS. In his report, Professor Enthoven intended that the individual patient would be the purchaser, where he proposes:

> Moreover, it is possible that such GP practices might become competitors for patients, thereby adding an element of consumer choice that has not been present in the NHS (Enthoven 1991:68).

In reality, purchasing is performed and regulated en-block by the District Health Authority, and subsequently by the Health Boards. In any given geographical area monopoly and monopsony[74] situations are regulated. Dawson (1994) argues that within the NHS it is not a simple inverse relationship which exists between the degree of competition and the published prices for care. Rather, contracts are negotiated by bargaining which is highly context specific and has long term collaborative objectives. The level of intervention by the government prevents the market from establishing what is of real value to patients. The moral significance of this position is highlighted by Sandel where he explains:

> Market-mimicking governance is appealing because it seems to offer a way of making political choices without making hard and controversial moral choices (Sandel 2009b).

The second consequence of government interventionism concerns the moral agency of staff. This is not to provide a wholly negative analysis of the NHS reforms, as much was achieved in improving the cost efficiency of the system. However, the argument is attempting to highlight the consequences of a quasi market, as being the lack of discussion on moral value in public life, and the inability of the market to identify what is of moral value within a democratic society.

The 1980s and 1990s NHS reforms introduced a new form of management which involved governance of staff by market principles (Clatworthy et al. 2000). With the introduction of Trusts, management was devolved to the Board of Directors, who had

[74] 'Economics. A market situation in which there is only one buyer (Soanes & Stevenson 2003:1136)'.

to compete with other trusts for resources (Cutler 2000). In this new structure terms and conditions of staff employment would be determined locally by the trust, where previously this was established at a national level (Buchan 2000). Salience was given to performance management which translated into clinical targets. Enthoven predicted how the Trust strategy would be broken down into annual personal objectives when he said; The success of staff would be much more tied to the success of their hospital than it has been in the past (Enthoven 1991:66).' The economic theory presupposes that individual health professionals can be directed and ordered to care, in the same manner as factory workers manufacturing an inorganic mechanical component. It is significant to note that the output of health care production is measured in terms of waiting lists for particular departments such as Accident and Emergency, or for specific operations such as hip replacement. The importance of performance management can be evidenced in the 77.7% increase in NHS managers from 1997-2005 (House of Commons Health Committee 2006), and in the volume of targets;

> The number of performance indicators multiplied. So did the number of targets, a trend across all government departments led by the Treasury. At the peak, NHS managers reckoned they had to meet 300-plus targets (ministers claimed a somewhat lower figure). And if targets were not met, there were sanctions (Klein 2007:41).

Care as merchandise, and the selling of care as commerce is organized and funded by the government, mainly through target setting and resource allocation. Trusts then develop Health Improvement Plans with the local Health Board. This is then developed into a Trust strategy and implemented by the use of annual personal objectives for

health professionals. Staff are then appraised on how successful they have been in implementing the Trust strategy.

3. Caring as Commerce

Bernard-Henri Lévy usefully points out that under Voltaire and Diderot commerce had a double meaning. In addition to meaning the exchange of merchandise 'it was a saying the relationship between souls and minds (Lévy 2008:15)'. It seems as if it may be in this secondary definition that a tension develops for health care professionals. As they use their Self in the therapeutic encounter with the Other. Levinas captures this tension where money is the medium of interchange between individuals;

> In the transaction, the action of one freedom over another is achieved…It keeps individuals outside the totality since they dispose of it; and, at the same time, it includes them in the totality, since in commerce and transaction the man himself is bought or sold: money is always wages to some extent (Levinas 2006a:32).

This point has become important within health care as staff performance is judged by the degree it is aligned to the Trust strategy. Sartre is in accord with Levinas regarding this tension between the individual and as also part of a community where he explains;

> It is the world which makes known to us our belonging to a subject-community, especially the existence in the world of manufactured objects (Sartre 2000:423).

The contrast that begins to emerge in caring as commerce is the degree to which patients are considered objects or subjects, and this point requires investigation in

relation to the potential totalisation of staff within an organization predicated upon a quasi market economy.

With staff objectives which are aligned to the Trust strategy, the personal objectives are dependant on the line managers' objectives, in a role of subordination. Sartre develops the tension between the I and the We by discussing how through work individuals are constantly exposed to the tension between having an individual identity and being part of a group identity. He uses two helpful examples to bring out the distinction between individuality and the 'They' or 'We'. In *Being and Nothingness* Sartre uses the example of the subway where – as similar to the Trust employment objectives - it is the ends that the individual pursues which are defining:

> My immediate ends are the ends of the "They," and I apprehend myself as interchangeable with any one of my neighbours. In this sense we lose our real individuality, for the project we are is precisely the project which others are (Sartre 2000:424).

In his later work (*Notebooks For An Ethics*), Sartre compares the artists work and the work of a subordinated factory worker who is involved in some 'collective undertaking' (Sartre 1992:129). The comparison brings to light how the artist can distinguish their individuality in the work, where the contribution of the collective worker gets lost in the whole. The effect on an ethics is important as the collective worker senses a diminished responsibility where he states;

> At the same time, it also has a density of being that allows me to avoid the anxiety of being responsible for my I (Sartre 1992:130).

The next section explores the concept of responsibility in terms of caring for patients within the legal framework.

4. Defining Responsibility in Law-the 'Duty of Care' Concept

Ethics and law converge when considering the question of responsibility. In law, the 'duty of care' is set out within the Tort of negligence. Torts are civil wrongs (Vanstone 1998). 'Tort' comes from the Latin word *tortus* meaning twisted or crooked. It is a wrongful act or omission (Martin & Law 2006). Negligence as a distinct tort began with the Scottish case of Donoghue v Stevenson (1932 S.L.T. 317). A brief sketch of the background to this case will be given as it provides a stark contrast to Levinas' view of responsibility where:

> To be the other's hostage, in Levinas's terminology, is to be obligated to an immemorial debt that I do not remember contracting. This obligation, which is not voluntary, holds me to a condition of passivity, like that of creation, where I am neither the author of myself nor self-contemporaneous. Moreover, I am obligated, in Levinas's frequent phrase, "straightaway" (*d'emblee*). This is to say that the obligation is immediate and does not go by way of the theoretical (Levinas 2001:7).

Levinas views responsibility for the other in a radical way in comparison to the legal system. The history of the Donoghue case is that May Donoghue found the remains of a decomposed snail within her ginger beer drink which she had ordered. This was in Paisley in 1928. Donoghue brought an action in law against the manufacture of the

drink; David Stevenson. Twice (April 1929, and in June 1930) the Court of Session ruled that there was no legal authority allowing a claim for damages against a manufacturer where no contract existed. It was only when the House of Lords recognized her claim for status as a pauper, did the appeal proceed (Taylor 2004). In examining the legal authorities in Scottish and English law, Lord Atkin commented;

> It is remarkable how difficult it is to find in the English authorities statements of general application defining the relations between parties that give rise to the duty (1932 S.L.T. 317: 8).

In law, it has been, and remains difficult defining the relations between individuals that give rise to a 'duty of care'. In the Donoghue case, May suffered 'from shock and severe gastro-enteritis (1932 S.L.T. 317:2)' as a direct result of consuming the contaminated drink. She was unable to pursue her case as one of contract law because her friend had bought the drink so no direct contract existed between her and the manufacturer. It would have been a difficult case for May to sustain because she had to retain her legal team who were pursuing her case without a fee. Ms. Donaghue also had to gain the status of a pauper because she was unable to put up the security for the cost of the case. Further, it should be added that she had to take her complaint to three different courts before it was recognised that a relationship existed between the manufacturer of the drink and the plaintiff. It is also suggested by Taylor (2004) that Ms Donaghue would have had great difficulty in finding a solicitor who would have been prepared to take her case. However, her solicitor had three weeks previously acted for the unsuccessful pursuers where mice were found in bottles of aerated water.

In contrast for Levinas:

> The expression the face introduces into the world does not defy the feebleness of my powers, but my ability for power.[75] The face, still a thing among things, breaks through the form that nevertheless delimits it. This means concretely; the face speaks to me and thereby invites me to a relation incommensurate with a power exercised, be it enjoyment or knowledge (Levinas 2008b:198).

The contrast found by considering Levinas' work helps to uncover some of the main philosophical discussions within jurisprudence, which can be identified in the speech of Lord Atkin in 1932, and evidenced today in the legal transcripts being analysed. Some of the relevant questions within legal philosophy are concerning whether law and morality are separate, to what extend there should be politicisation of law, and also the source of the moral ought.

In stark contrast to the legal system, Levinas places ethics in the form of the relation to the Other prior to reason, law, justice, universality, and politics. There is an important development in Levinas' thinking between the writing of *Totality and Infinity*, and the more recent text *Otherwise than Being or Beyond Essence*. In *Otherwise than Being or Beyond Essence*, Levinas abandons the structure of phenomenology in different strata. In the translator's introduction Alphonso Lingis outlines this change:

> The ethical relationship with alterity is now described with concepts opposed to those of presence, the present, aim or intentionality. These concepts will be used to formulate saying itself, and the signifygness of speech founded on an existential structure of being for-the-other, in terms of making-contact that precedes and supports making signs (Levinas 2008a: xxi & xxii).

[75] *Mon pouvoir de pouvoir'-My ability for power.*

In a similar fashion Levinas makes

> … an attempt to traverse the passage from ethics to politics. In each of his two major works, *Totality and Infinity* and *Otherwise than being or Beyond Essence*, Levinas endeavours to build a bridge from ethics, conceived as the nontotalizable relation with the other human, to politics, understood as the relation with the third party (le tiers),that is, to all the others that make up society…(Levinas 1996:161).

The tension in these relationships can perhaps best be seen where Levinas states:

> To be disengaged from the totality while at the same time accomplishing a work in it is not to stand against the totality, but for it - that is, in its service. To serve the totality is to fight for justice. The totality is constituted by violence and corruption. The work consists in introducing equality into a world turned over to the interplay and the mortal strife of freedoms. Justice can have no other object than economic equality. It is not born of the playing out of injustice itself-it comes from the outside. But it is illusion or hypocrisy to assume that, while born outside of economic relations, justice can be maintained outside, in the kingdom of pure respect (Levinas 2006a:31).

Ethical care as the 'nontotalizable relation with the other human' is explored in law through the concept of negligence. For negligence to be proven four elements have to be established. These are that a duty of care was owed to the individual, that that duty was breached, causation is established, and damages are identified (Jones M. 2003). There are different tests for establishing if the individual was responsible for owing a duty of care (Leng 2007). The test for determining whether a duty of care exists where there is physical damage - such as in clinical negligence - is a three tier test which was

established as legal precedent in the case of *Caparo Industries Plc v Dickman* ([1990] 2 AC 605). The first two elements are significant in establishing clinical negligence, in that much time and care is spent in exploring if a duty of care was owned to the individual, and then if that duty was breached.

To decide if a duty of care is owed to the Other in law, the tripartite *Caparo Dickman* test is applied. This involves considering the following three questions; Was damage foreseeable? Is the relationship between the parties proximate? And, Is it fair, just and reasonable to impose a duty of care? Establishing a legal relationship is based upon Lord Atkins' legal principle which was expressed in *Donoghue v Stevenson;*

> The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, Who is my neighbour? Receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be— persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question. (1932 S.L.T. 317:8).

In a lecture to the Personal Injury Bar Association (PIBA) Conference, Norris (2009) outlined the potential confusion between legal duties, and what would be better termed social obligations. To illustrate the point he uses two scenarios. In the first, an individual is flattened by a lorry when the bystander fails to suggest that they might look to the right before crossing the busy road. In the second scenario, Norris cites a judge who used the example of an absent minded walker who strides along with their

head in the air, 'oblivious to the approaching cliff's edge (Norris 2009:114)'. The reason for his conclusion - 'the explanation can only be that in all those cases the law imposes no duty of care (Norris 2009:114)-is that they fail the *Caparo Dickman* test. The area where the test fails is that of *proximity*, in that the individual had not assumed any responsibility for the unfortunate victim. And also that the victim had not relied upon the bystander, and if they did, they had no reasonable basis for doing so.

Before considering the further restrictions law places upon the standard of relationship with the other, it may be worth bringing out the contrast in Levinas' position. In responding to a question from Philippe Nemo, regarding the concept of the Other having an elevated position Levinas clarifies the concept of The Face;

> The first word of the face is the "Thou shalt not kill." It is an order. There is a commandment in the appearance of the face, as if a master spoke to me. However, at the same time, the face of the Other is destitute; it is the poor from whom I can do all and to whom I owe all. And me, whoever I may be, but as a "first person," I am he who finds the resources to respond to the call (Levinas 1985:89).

For Levinas, the relationship with the Other is *primal.* It already has *proximity,* and regarding resources, it is set in the context of the *infinite* - 'I am he who finds the resources to respond to the call' (Levinas 1985:89). In stark contrast to this, the history of the tort of negligence has been one of narrowing the definition of a legal relationship. The case of *Donoghue* (1932 S.L.T. 317) had overturned the old cases which had

limited the scope of duty to 'privity of contract'[76]. Two attempts, in 1970 (Home Office Dorset v Yaught Co. Ltd [1970] 2 W.L.R. 1140) and 1977 (Anns v Merton London Borough Council [1977] 2 W.L.R. 1024) were made to widen the scope of the duty, but both were overturned in favour of a narrower definition of responsibility (Leng 2007). Deakin et al. confirm this appraisal where they state;

> The courts have turned their back on the broad formulations adopted in Anns and Dorset Yaught and confined Donoghue v Stevenson to cases of physical damage. Incrementalism, however, has come to acquire a much more rigid and narrow form in the English common law than it has in other parts of the Commonwealth where it is seen as a means of preserving flexibility and not as a limiting tool (Deakin et al. 2008: 128).

In trying to establish if the health professional has a legal duty to the Other, the courts have traditionally applied the *Bolam* test ([1957] 1 W.L.R. 582). The expected standard of care of any healthcare professional was defined by Mr Justice McNair where he directed the jury;

> …that he is not guilty of negligence *if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art*. ([1957] 1 W.L.R. 582: Line 587) (emphasis added).

The Bolam test is significant in analysing the legal transcripts on a number of levels. Firstly it roots the moral ought in what others would do, rather in what ought to be done. It derives a value from a fact. Samanta et al. (2003) argues that the Bolam test allows

[76] The doctrine of privity in contract law provides that a contract cannot confer rights or impose obligations arising under it on any person or agent except the parties to it.

health care professionals to set the legal standard for themselves. From this perspective it is a powerful tool in deciding if there is a duty of care owed to the patient. Brazier (2000) explains how the use of the Bolam test can be used to render claims sufficiently incontestable, to prevent them from ever reaching the courts. Secondly, the Bolam test and the use of expert opinion have revealed the courts as being susceptible to bias (Dwyer 2007, 2008). This point was discussed above. And finally, the Bolam test;

> …would appear to have crossed the boundaries of diagnosis and treatment, as well as the limits of medicine, thereby enlarging the role of the doctor to that of a moral arbiter (Samanta et al. 2003:444).

The different areas of potential bias within the Bolam test produced further doctrinal changes in the ruling of Bolitho v City and Hackney Health Authority ([1997] 3 W.L.R. 1151). In Bolitho, Lord Browne-Wilkinson stated;

> The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion *has a logical basis* ([1997] 3 W.L.R. 1151).

In this House of Lords ruling Lord Browne-Wilkinson had reduced the ability of health care professionals to set the legal standard of care for themselves. The professed opinion now must stand up to logical analysis by the judge.

It can be established from the above legal doctrine, that in law, the legal relationship is defined through the ‘duty of care’ owed to the Other. The moral ought is defined by what other professionals would do in a similar situation (‘in accordance with the

practice accepted as proper by a responsible body of medical men skilled in that particular art'). This reduced view of responsibility then has to be considered within the overall purpose of the tort of negligence, which contains elements of both Corrective and Distributive justice (Lippke 1999).

Within law the duty of care has expanded from privity of contract to a more inclusive duty, however there remains a clear distinction between physical and psychiatric harm[77]. While there has been much progress within legal jurisprudence on the topic in the past century, there remain severe restrictions on the scope of recovering damages within this area of tort law (Deakin et al. 2008). The courts have been slow in accepting psychiatric harm as a head of damage within tort law. It was not until 1983 that Lord Bridge in the case of McLoughlin v O'Brien expressed the problem facing judges when he said;

> Moreover, psychiatric medicine is far from being an exact science. The opinions of its practitioners may differ widely. Clearly it is desirable in this, as in any other, field that the law should achieve such a measure of certainty as is consistent with the demands of justice. It would seem that the consensus of informed judicial opinion is probably the best yardstick available to determine whether, in any given circumstances, the emotional trauma resulting from the death or injury of third parties, or indeed the threat of such death or injury, ex hypothesi attributable to the defendant's negligence, was a foreseeable cause in law, as well as the actual cause in fact, of the plaintiff's psychiatric or psychosomatic illness ([1983] 1 A.C. 410: Paragraph.433).

[77] Privity of contract is the relationship that exists between the parties to a contract. One of the key features is that only the parties to the contract could sue or be sued under the contract. Third parties could not derive rights from someone else's contract.

Psychiatric harm is difficult to define in law. There are many limiting devices to restrict potential claimants, and there have been many attempts to define the types of relationships where it would be reasonable to understand that due to closeness, people could suffer psychiatric harm. An example of this would be where Lord Oliver argued that the policy of tort law was on the whole to confine any action in negligence to the 'primary' accident victim (Alcock v Chief Constable of South Yorkshire [1992] 1 AC 310). There remains an imbalance in the way that physical and psychiatric harm is viewed within tort law. In that harm to the body takes precedence. This discussion can be traced through the case of McFarlane v Tayside Health Board ([2000] 2 A.C. 59), when George and Helen McFarlane had a healthy baby following the failure of a Vasectomy. The House of Lords ruled by majority that the couple should succeed in a claim for pain and suffering arising from the birth, but rejected the claim for economic losses due to the birth of the child. The concept of psychiatric harm has been introduced in this chapter as part of the argument in the challenge of defining responsibility in law. However, it will be discussed in more detail in the next chapter within specific legal cases.

5. Conclusion

Hermeneutics has been applied as a framework to uncover the challenges of interpreting text in the 'interpreter's now expanded horizon' (Schmidt 2006:8).This has involved following the same legal process that the jurists took which involves identifying similar preceding cases, identifying legal precedent, and consulting legal axioms. This process is identified at the beginning of each legal transcript. This has been found to be particularly relevant in situating the analysis into a historical context, which includes a constantly expanding horizon due to the ongoing advances in

biomedical technologies. Also recognised was the fact that multiculturalism beings a richness to the discourse, but at the same time the many world faiths share the common challenge of responding rapidly to the advances in biomedical technology. This discussion is developed further in Chapter Six in relation to contemporary ethical issues.

The concept of justice has been introduced in this chapter and has been explored in the rich, but challenging, context of interpreting case law in the area of clinical negligence. The work of Levinas was also introduced and developed to provide a contrasting view of responsibility in caring for patients. Then the politicization of tort law was identified through the technical definition applied in the 'duty of care' in law. With the relationship established between the 'duty of care' owed, the consequent boundaries of responsibility, and potential liability of a health system, cost containment as an aspect of justice was recognised.

Given some of the challenges identified in this chapter regarding enculturation, the next chapter aims to consider the philosophical argument that ethics is prior to ontology.

CHAPTER SIX: EITHER/OR; THE AUTHENTIC INDIVIDUAL

> Every man, however modest his talents, however subordinate his position, feels a natural need to form a view of life, a conception of life's meaning and aim (Kierkegaard 1992b:493)

Introduction

Chapter Five attempted to situate the study in its historical context by outlining the current approach to the legal process taken in cases of clinical negligence. By exploring the concept of responsibility towards the other from a legal and ethical perspective, the discussion teased out the constant either/or question staff have to face regarding choosing the ethical, and the limits set upon responsibility towards the Other. The Other in this context, being predominantly, but not exclusively, patients.

The aim of chapter is an invitation to consider the philosophical argument that ethics is prior to ontology. This claim is central in the work of Levinas, where the call of the other has priority. This is something which is prior to any theory about being. This claim will be further explained as the chapter develops. A portfolio containing five cases of clinical negligence will be used as the primary empirical source as the testing ground for a philosophical analysis of real cases. A purposive selection criterion has been used to imitate the most common cases presenting to the NHS Litigation Authority. The selection includes five clinical specialties of: Surgery, Obstetrics &

Gynaecology, Medicine, Psychiatry & Mental Health, Community Care, and one category ‘Other’. The details of the selection criteria are provided in Chapter Two.

The analysis of the real cases of clinical negligence unravels some of the dynamics contributing towards ethical desensitisation. Sartre, Levinas, and Kierkegaard are applied as the main theorists to uncover and tease out some of the totalising effects within the health care system from the political, professional, and organisational levels. The critical point is the influences which lead to lowering the bar on the quality of patient care.

Although the clinical incident in some of these cases occurred more than ten years ago, they remain current in law as long as the claimant has the right to appeal. Some of the cases have exhausted the appellate process, but that in itself contributes to the discussion on the concept of justice.

The selected legal transcripts provide insight into what would be otherwise the private lives of individual patients, and members of health care staff. The advantage gained by the transcripts is that they provide an overview of the whole process which traces the clinical situation through to the final legal ruling on the case.

The main approach taken in this chapter is to take a snapshot in the historical time frame of health care delivery within the NHS. Then armed with this information to focus upon the ethical aspect of this care. Within this chapter the analysis is centred on the concept of responsibility towards the patient. It develops the argument set up in the

previous chapter, by continuing to explore the philosophical category of *kinesis*, and the concept of responsibility through the legal 'duty of care'. Likewise, it continues to develop a contrasting view of responsibility as presented by Kierkegaard, Sartre and Levinas.

In the previous chapter, Levinas presented a view which focuses upon the particular individual and resists the mediation of the universal. Similarly, Kant identified the consequences of considering patients and law-making as objects. Where such a teleological view considers objects as *purposive* and as products of intentional acts. Both of these perspectives will be sustained in the current analysis which will now also involve Kierkegaard and Sartre in more detail.

For Kierkegaard, and many existential philosophers, to be a self, to exist as an individual is always dynamic and to be under way. Kierkegaard's perspective is particularly useful because of the way it sets the whole scene in relation to other philosophers, and also for the dynamic relation between the individual and the organisation, or *Crowd*. It also has a number of unique features within the definition of a 'self' such as transcendence, and the way the self relates to itself through the absolute. For Existentialists, the individual first exists, and then develops an *essence*. In professional life – as in all aspects of life - the individual must first constitute a self, before it can care for another in a constructive, therapeutic manner. In the health care literature this concept is captured in the research on the socialisation and professionalisation processes. Kierkegaard's work will be discussed below in relation to the selected cases. On controversial points it will be discussed in relation to Jean-

Paul Sartre's philosophy. Amongst other issues, this coupling allows exploration of existentialism along the theistic-atheistic continuum, and a posthumous review of Kierkegaard's philosophy. First it will look at the definition of a self and how this self is constituted by others, the organisation, and then how this self relates to the patients.

Kierkegaard is often mistakenly discounted as a 'religious' philosopher, and there is a lingering myth that he is an irrationalist. Although he challenged the organised religion of the established Danish Church, he was interested in a particular ontology that he considered the established church of that time to be stultifying. Similarly, Jean-Paul Sartre outlined this 'becoming', but for him it was becoming as an Atheist. In both approaches the importance of the structure is about becoming, and less about the particular type. Some philosophers state that what Kierkegaard was doing with his particular model of the self was to unsettle people about whether they could have faith - in the same way that Socrates did with knowledge. The example given to substantiate this claim is from the *Attunement* within *Fear and Trembling*. Here Johannes de Silentio is considering the story of Abraham going to sacrifice his son Isaac and he says:

> There was once a man: he had learned as a child that beautiful tale of how God tried Abraham, how he withstood the test, kept his faith and for the second time received a son against every expectation. When he became older he read the same story with even greater admiration, for life had divided what had been united in the child's pious simplicity. The older he became the more often his

> thoughts turned to that tale, his enthusiasm became stronger and stronger, and yet less and less could he understand it[78] (Kierkegaard 1985a:44).

Kierkegaard centres his ontology and ethics in his definition of the self;

> The human being is spirit. But what is spirit? Spirit is the self. But what is the self? The self is a relation which relates to itself, or that in the relation which is relating to itself. A human being is a synthesis of the infinite and the finite, of the temporal and the eternal, of freedom and necessity. In short a synthesis. A synthesis is a relation between two terms. Looked at in this way a human is not yet a self (Kierkegaard 1989:43).

At the heart of Kierkegaard's philosophy he seeks to bring together our Greek and Judeo-Christian heritage (Dreyfus 2006). In his definition of the self above, he sets out the structure as two sets of contradictory factors. The 'Body' which is 'finite', 'temporal' and 'necessary'. And then the 'Soul' which is 'infinite', 'eternal', and has 'possibility'. Dreyfus points out that prior to Kierkegaard, the Greek philosophers viewed these two sets of contradictory factors as *combined* '[…] Where the self would be in hopeless self-contradiction (Dreyfus 2006:140) ', rather than as a *synthesis* as outlined in Kierkegaard's definition. The detailed structure of Kierkegaard's self can be gleaned from his many books, but the project of becoming an individual is mainly in *Either/Or* (1992b), and *Stages on Life's Way* (1983) and concluded in *The Sickness Unto Death* (1989). It is in the latter book, and from the basic premise of *synthesis* above, that he outlines the different ways of being, in the *Aesthetic*, *Ethical*, and

[78] The history of this Old Testament story regarding Abraham and Isaac is pre- Ten Commandments and Levitical law. This could be of hermeneutical importance as it is in more of a Virtue ethics context than one of external regulation.

Religious spheres of existence. Kierkegaard provides a rich polemical of these ways via a portfolio of characters. However, when the literature is stripped back, it reveals an ontology containing three ways of being.

In the existential position of *Aandløshed* (Spiritlessness) the psyche[79] has a sense that the self is a contradiction but lives in distraction (Hannay and Marino1998:19). Alternatively, in the next existential position the self can choose to relate to the two opposing factors in a positive, or negative relationship. Kierkegaard explains these where he proposes:

> In a relation between two things the relation is the third term in the form of a negative unity, and the two relate to the relation and in the relation to that relation: this is what it is from the point of view of soul for soul and body to be in relation (Kierkegaard 1989:43).[80]

The negative unity of this position is where there is disequilibrium because the individual denies one of the sets of factors, and behaves as if only the other aspect of the self exists. So, if they choose only the temporal and body, they lose the eternal and soul. The positive form of this position is where the individual tries on their own to express both sets of factors, but this turns out to be futile. Kierkegaard (1992b) gives the example of the individual who tries to make facticity absolute, only to find that they lose possibility, and end up paralysed by fatalism. Only by being in an unconditional

[79] Psyche' was chosen over 'individual' because if the person does not choose an 'unconditional commitment' they do not become an individual. Instead they are part of the crowd or herd.

[80] Hannay (Kierkegaard 1989:167,168) provides two useful points (Note 5) regarding the translation of the above sentence. The first relates to the word unity which could also be replaced by 'unit', and also that 'from the point of view of' can also be translated as 'under the qualification of'.

commitment can the self get the two sets of factors into a positive relation. Kierkegaard states this only authentic existential position thus: 'Such a derived, established relation is the human self, a relation which relates to itself, and in relating to itself relates to something else' (Kierkegaard 1989:43).

While this reduced synopsis reveals Kierkegaard's ontology clearly, his prose eloquently emphasises the poverty in all but this last existential position[81]. Crucially, and uniquely to Kierkegaard, is the third aspect of this relation which involves the relation to the infinite. If the individual is unable to successfully bring the opposing factors together they are in despair; 'The imbalance in despair is not a simple imbalance but an imbalance in a relation that relates to itself and which is established by something else' (Kierkegaard 1989:44).

Kierkegaard indicates that this 'something else' is an unconditional commitment. In *Fear and Trembling*, for the sake of brevity he uses the example of a young lad falling in love with a princess, but he concedes that; '[…] Any other interest whatever in which an individual concentrates the whole of life's reality can, when it proves unrealizable, give rise to the movement of resignation' (Kierkegaard 1985a:70,71).

Kierkegaard and Sartre share some common ground here. For Kierkegaard the pre-ethical stage of the *Aesthetic* is roughly equivalent to a life of immediacy where the

[81] To emphasise the position within the Aesthetic stage -where the individual chooses the finite, temporal, facticity, and body, - Kierkegaard uses 'Don Juan' in 'Stages on Life's Way' and in 'Either/Or'. Don Juan lives only for the sensual satisfaction of the present moment, portrayed as a tireless seducer of women. Kierkegaard also emphasises 'immediacy' through humour in 'Stages on Life's Way' where the invitations to the banquet are sent out at the last minute, and there is a work crew ready to dismantle the gathering place as soon as the banquet is finished (Malantschuk 2005).

individual is concerned only with their physical body and socially determined identity. This would be the concept of *facticity* in Sartre's work. For both, the individual standing in an immediate relation to something, is to be unmediated by critical reflection. As explained below, this for Sartre would be *being-in-itself.*

Sartre's ontology is constructed as an opposition to *being-in-itself* (ětre-en-soi) which is a non-conscious mode of being, in favour of *being-for-itself* (ětre-pour-soi), which is a conscious desire for *Being.* All of the factors which contribute to the situation individuals find themselves in is termed *facticity* by Sartre. Where Kierkegaard has three stages of development (Aesthetic, Ethical and Religious), Sartre has three *ekstases*[82] where the *being-for-itself* is separated from its Self. These three are, 'Temporality', 'Reflection', and 'Being-for-others'. Within the stages there is a progressive movement from inwards (enstasis), out to the Other. 'Temporality' is nihilation of the *being-in-itself* by *being-for-itself,* in the three dimensions of past, present, and future. This is significant to the cases being discussed as here Sartre is reversionary in explaining that individuals are more than the roles they play. With the waiter in the café Sartre highlights someone paralyzed by duties and obligations to the point that he has become like a robot. In discussing 'temporality' Sartre states;

> Society demands that he limit himself to his function as a grocer [...] There are indeed many precautions to imprison a man in what he is, as if we lived in perpetual fear that he might escape from it, that he might break away and suddenly elude his condition (Sartre 2000:59).

[82] Used in the original Greek sense of 'standing out from' (Sartre 2000:631).

By *transcending* their *facticity* individuals can realize their freedom, and in so doing realize that the past is not a reliable predictor of the present or future. The *'transversal'* function of consciousness allows the individual to review the past from the perspective of existential freedom.

In 'Reflection' the *being-for-itself* tries to adopt an external view of its Self. This aspect has similarities to Kierkegaard's *confinium*[83] of irony. In Kierkegaard's work there are two areas of *confinium.* The transitional area of irony is to be found between the *Aesthetic* and the *Ethical* stages, and the transitional area of humour is between the *Ethical* and *Religious*. It is the territory of irony which has similarities to Sartre's *being-for-itself,* for ironists disengage radically from society realising that all cultural norms are relatively valid. According to Kierkegaard this insight is gained from recognising the ethical infinite requirement (Kierkegaard 2009b). In Sartre, the final *ekstasis* is where the *being-for-itself* discovers it has a *Self-for-the-other* (ětre-pour-autrui). In most of the cases reviewed it will be seen that the individual failed to choose their Self. In failing to choose their Self, they then did not have a *Self-for-the-other*.

In order to consider the main aim of this chapter, which was to explore the claim that ethics is prior to ontology, this chapter is going to apply the legal theory discussed in the previous chapter to consider clinical negligence in more detail.

In order to achieve this goal, this chapter continues under the following sections:

[83] *Confinium* is a concept used by Kierkegaard to denote a 'border territory' (Kierkegaard 1992a: 501 & 502).

Emotion

Most of the legal transcripts analysed contain an emotional dimension to the existential situations (e.g. Ann Marie Rogers p.229, Harry Coleman P.243, Naazish Khan p.254). The first legal case to be introduced (Michelle Anne Brindley v Queen's Medical Centre University Hospital NHS Trust [2005] EWHC 2647 (QB)) is predominantly concerned with psychiatric harm, and therefore the role of emotion in clinical care.

Sensitive nursing and medical care from a Sartrean and Kierkegaardian perspective is dependant upon the degree to which the individual chooses their Self. The question of 'What ought I to do?' in any given situation, is related to what the individual considers regarding 'What *can* I do?' (Stack 1973). Kierkegaard uses the method of *Either/Or* in relation to this and emphasises the importance of choice. Sensitive individualised care is based upon the patient in their changing dynamic context. Kierkegaard brings out the ineptitude in being part of the *crowd* where he explains;

> Your activity is designed to keep yourself hidden, and in that you succeed, your own mask is the most enigmatic of all; for you are nothing and exist merely in relation to others, and you are what you are in this relation (Kierkegaard 1992b:479).

One of the key characteristics in this case (Michelle Anne Brindley v Queen's Medical Centre University Hospital NHS Trust [2005] EWHC 2647 (QB)) is the role of emotions in caring for patients. For Kierkegaard, emotions are perceptual states and thereby provide epistemic access to the moral situations they concern (Roberts 1998). Emotions, considered as part of consciousness, are constitutive of character. The consequences for patient care can be seen in the choice of either/or choosing oneself. Either:

> Thus consciousness is the decisive factor. In general, what is decisive with regard to the self is consciousness, that is to say, self-consciousness. The more consciousness, the more will; the more will, the more self. Someone who has no will at all is no self (Kierkegaard 1989:59).

Or:

> Or can you imagine anything more frightful than that it might end with your nature dissolving into a multitude, with your really becoming many, becoming, like that unhappy demoniac, a legion, and in that way losing the innermost, the most holy thing in a man, the unifying power of personality? (Kierkegaard 1992b:479).

This case concerns three main issues, which include the claimant transcending her *facticity,* the role of clinical guidelines, and the influence of a consultant in setting the standard of care.

The case of Brindley v Queen's Medical Centre University Hospital NHS Trust ([2005] EWHC 2647 (QB)) involves Mrs Michelle Anne Brindley who claims that the NHS Trust negligently failed to give her proper advice during the second trimester of her pregnancy. At twenty-two weeks gestation Mrs Brindley was attending an ante-natal clinic. At this time a Consultant Radiologist (Dr Peter Twining) informed her in clear terms that the ultrasound scan revealed the foetus had no kidneys. Mrs Bindley's witness statement concurs with Dr Peter Twinings statement where he said:

> I informed the Claimant of my findings on the scan. I explained to her that I could not see any kidneys and that termination of pregnancy was an option for her. I did not discuss termination of pregnancy at length, instead making arrangements for her to see Professor James to discuss the findings. I provided the Claimant with my report (exhibit PT5) and made arrangements for her to see Professor James. (Paragraph 103 [2005] EWHC 2647 (QB).

Following this consultation Mrs Brindley was very upset and visited her father along with her husband Paul. Mrs Brindleys father arranged for her, her husband, and for himself to see Professor James that same afternoon. Professor James was Professor of Fetomaternal Medicine, Director of the High Risk Pregnancy Unit which Mrs Brindley was attending, and also the consultant in charge of her obstetric care. When Mrs Brindley visited Professor James he remembered her being 'extremely distressed (Paragraph 139 [2005] EWHC 2647 (QB)', he recollects them saying the problem was that the baby 'had no kidneys, was going to die because of that, and there would have to be a termination (Paragraph 152 [2005] EWHC 2647 (QB)'.

Faced with the facts Mrs Brindley recognised her freedom to choose. Presented with the picture of her having a baby which was deformed and would die, she chose to transcend these facts (*facticity*). When the consultant radiologist (Dr Peter Twining) explained the situation Mrs Brindley became distressed and sought a second opinion. Equally, Professor James was presented with a difficult situation in that he was faced with a distressed woman, and his professional opinion differed to the diagnosis provided by Dr Twining. For Sartre, existence precedes essence, and Existentialism is not as it has been challenged as Quietism. Sartre explains:

> The doctrine I am presenting before you is precisely the opposite of this, since it declares that there is no reality except in action. It goes further, indeed, and adds, "Man is nothing else but what he purposes, he exists only in so far as he realises himself, he is therefore nothing else but the sum of his actions, nothing else but what his life is (Sartre 1973:41).

Sartre includes in this the choosing of emotions. That is, he believes individuals choose their emotions. Following the consultation with Professor James Mrs Brindley felt reassured that all was well, and she changed her mind about the necessity of having a termination of her pregnancy. The legal transcript reports the information which helped Mrs Brindley to trust Professor James' opinion;

> The witness statement of Mr Brindley dealt in paragraph 11 with what was said by Professor James on the afternoon of 13 May 1999. They duly met with Professor James who carried out another scan. He left them with the impression that he could certainly see something in the area where the kidneys should be and Mr Brindley remembered him saying that the fluid must be coming from somewhere

> and that therefore they must be OK as it could only be the kidneys which could produce it. By that stage, they were both very confused at the conflicting stories they had been told and from the emotional strain of it all. However, Professor James left them feeling reassured and certainly gave no impression there would be any problems with the baby, but he did tell them that the claimant would need to go back to the hospital regularly for the fluid to be checked and for the baby's heart to be monitored. There was no mention whatsoever of the need for any abortion and, as far as Mr Brindley was aware, there was no likely problem with Owen's lungs as this had never been mentioned to him ([2005] EWHC 2647 (QB) : 50).

The extent of emotion in these situations is however significant as can be seen at paragraph 44;

> The claimant was asked to explain why, on her version of events, she was still distressed at the end of the discussion with Professor James on 13 May 1999. She replied: Because I am a distressful person. I don't know if this aspect of my character hinders me taking in complex medical advice ([2005] EWHC 2647 (QB): 44).

This case highlighted the role of many of the professional guidelines, and one specific clinical guideline in everyday practice. Professor James had chaired the working group for standards developed by the Royal College of Obstetricians and Gynaecologists entitled; 'Fetal Guidelines for Screening Diagnosis and Management'. In his witness statement and in examination he admitted to not following his own guidelines on a number of significant areas.

Some examples are Professor James explained that when there had been a discussion of termination; '…his practice was to document a brief summary of what took place, and

he had no idea why he did not do that in this case (Paragraph 201[2005] EWHC 2647 (QB)'. Under Cross-examination; '…Professor James accepted that the records he made on 17 May and 3 June were substandard (Paragraph 183 [2005] EWHC 2647 (QB)'.

Similarly, in considering the guidance from the GMC on the crucial role of clinical notes and in the Royal College of Obstetricians and Gynaecologists document entitled; 'Fetal Guidelines for Screening Diagnosis and Management (1997)' section 3.7. states;

> Once fetal abnormalities have been diagnosed, it is helpful to provide a specific written or typed note or letter for parents. It is also useful to have this document duplicated for all professionals involved in the care of the parents so that everyone knows what has been discussed (Paragraph 8. [2005] EWHC 2647 (QB).

In response to Cross-examination of his clinical record keeping Dr Twining said;

> …it was not his practice to outline in the records his discussions with patients. He accepted that this was poor practice on his part, but he did not have the time to make entries of this kind in the records (Paragraph 111 [2005] EWHC 2647 (QB).

However, in choosing and making decisions, the individual doctor, nurse or patient chooses for all humanity. Sartre states that, 'In fashioning myself I fashion man' (Sartre 1973:30). In such decision making Sartre believes individuals are 'legislators for the whole of mankind (Sartre 1973:30)'. Since we do not know the outcome of our actions, and we cannot escape from a sense of profound responsibility, we should act in *anguish*. It is striking at this point to witness how ineffectual the clinical guidance is, and it raises

questions as to why the medical staff in this situation, while knowing the content of the guideline, chose to ignore it. The previous discussion from Kant on the *purposivness* of patients appears to be relevant here, and indeed Levinas on reducing *alterity* to Same. In discussing ends (*telos*) in relation to a world-historical view Kierkegaard explains:

> In a world-historical perspective there is much wider scope for this confusion, where it often seems as if good and evil obey a quantitative dialectic, and as if there is a certain magnitude of crime and cunning in relation to millions of individuals and entire peoples, where the ethical becomes as shy as a sparrow in a dance of cranes (Kierkegaard 2009b:118).

Such behaviour as documented in the legal transcripts has real consequences for any community or society. Kierkegaard's contribution towards politics aims to avoid the state's self-deification by proposing that each individual's actions are regulated in accordance with a higher ethical criterion (Dooley 2001).

The outcome of this case was that Mrs Brindley gave birth to Owen who has one small abnormal kidney, and also suffers from deafness and severe mental disability. While Professor James accepted in cross-examination that his reply was substandard practice, the judge found that the defendant is not liable to the claimant. Such dialectic with society from the state sets up a tension with the other as *alterity*. Kierkegaard seems to capture this dynamic where he outlines the impact the individual can have as part of society, and thereby contributing to a political framework;

> The ethical lays hold of the individual and requires of him that he refrain from all observation, especially of the world and of humankind; for the ethical as the internal cannot be observed by

> someone outside; it can be realized only by the individual subject, who is then able to know what lives within him, the only actuality that does not become a possibility by being known and that cannot be known just by being thought, since it is his own actuality, which before it became actual he knew as a thought-about actuality, i.e., as a possibility; whereas in respect of another's actuality, he knew nothing about it before, by coming to know it, he thought it, i.e., changed it into possibility (Kierkegaard 2009: 268).

Patients and staff who have made the difficult decision to present their complaint to the legal system do so primarily because their individual clinical care, (or staff have witnessed clinical care that), is considered to be substandard. For these individuals the clinical context is crucial, and what could be called their 'existential situation' at the time of the incident. Consideration will be given to the societal level in the next section, and also to the political implications of Kierkegaard's work in the next chapter (Chapter 7).

National opinion

In R. (Ann Marie Rogers) v. Swindon Primary Care Trust ([2006] EWHC 171 (Admin), [2006] EWCA Civ 392.), the applicant, who was a fifty four year old woman, had undergone a Mastectomy, breast reconstruction and auxiliary surgery for stage 1, HER2-positive breast cancer. During the course of her chemotherapy her son discovered on the internet that there was a type of breast cancer known as HER2 positive which could be treated with Herceptin. Accordingly, Ms Rogers asked her Consultant to test her for HER2, to which she tested positive.

At the time of the hearing[84] Herceptin was licensed for the treatment of stage 2 breast cancer, but it had not received a Product License from the Department of Health, and the National Institute for Health and Clinical Excellence (NICE) had not appraised its effectiveness[85]. However, Mrs Rogers consultant wrote to the medical director of the Swindon and Marlbourgh NHS trust informing him of the 'exciting' results of the Herceptin trials[86] (Piccart-Gebhart et al. 2005, Romond et al. 2005, Hortobagyi 2005) which had been presented to the American Society of Oncology in May 2005 (paragraph 6 [2006] EWHC 171 (Admin)), and asked if Ms Rogers could pay for Herceptin whilst remaining an NHS patient. The Primary Care Trust refused on the grounds that it did not fund the unlicensed use of Herceptin for stage 1 breast cancer. Dr Cole (consultant) agreed to treat the Claimant with Herceptin on a private basis, with Ms Rogers paying for the drug, but not for the medical care as Dr Cole waived his fees. Ms Rogers paid for the first two treatments, but when she was unable to afford the third treatment she sought legal advice. On the 21st of December 2005 Judge Charles granted permission to apply for judicial review and ordered the Trust to fund, and provide Herceptin until the determination of this order.

While Ms Rogers was coping with the news that she had breast cancer and attempting to receive the best medical care, there was a high profile debate being carried out in the national press. In September, Boseley (2005a) wrote an editorial on the leading cancer charity 'Cancer Bacup' launching a "dossier of delay", claiming that patients were

[84] 15th of February 2006.
[85] Herceptin obtained approval from NICE soon afterwards.
[86] The rationale for such a level of detail on the clinical evidence is to develop a discussion on the role of evidence, the development and use of Clinical Guidelines, and the way this can contribute to the patients' anxiety.

dying unnecessarily because 23 new drugs had not been given approval for use in the NHS by the National Institute for Clinical Excellence (NICE). In October the same health editor (Boseley 2005b) reported on a similar case to Ms Rogers, where Barbara Clark, a 49-year-old nurse with an aggressive breast cancer had won her battle to obtain NHS treatment with Herceptin, after she threatened to take her case to the European Court of Human Rights. It was only when another patient (Elaine Barber) was planning to take her primary care trust to the high court over its refusal to fund her Herceptin treatment that the then health secretary, Patricia Hewitt intervened in the debate (Asthana 2005). Hewitt bypassed the decisions of NHS regulators and NICE and informed NHS Trusts that they could not refuse to fund the drug on grounds of cost alone (Meikle 2005a, Meikle 2005b).

The personal anxiety in this Case can be seen in all of those closely supporting Ms Rogers. With her son researching the topic on the internet, by her consultant writing to the medical director of the trust and finally agreeing to treat her as a private patient. Ms Rogers's individual perspective on the situation can be gleamed from a statement to the press at the time;

> I have endured grueling chemotherapy and radiotherapy, and I am angry with my PCT refusing to fund the health treatment I need. I will continue to fight for Herceptin as it is vital in preventing the cancer recurring and allowing me to get my life back (Press Association 2005),

And also from her witness statement; 'It is only now with the Herceptin that I feel that I have been given a small part of my life back and I have been able to start thinking about the future' (Paragraph 9. [2006] EWHC 171 (Admin)).

Levinas develops this relation with the Other much further[87], and he would refer to this form of impersonal being as *"Il y a"*[88]. Levinas explains its meaning as:

> "*Il y a"* in the sense of *"Il* pleut," *"il* fait beau" ("it" is raining, "it" is nice outside). This "it" marks the impersonal character of this stage in which impersonal consciousness experiences something without objects, with-out substance- a nothing that is not a nothing, for this nothing is full of murmuring, a murmuring which is unnamed. In this horrifying experience of annihilation, the thematic of the "there is" roots the construction of a subject who, from out of the neuter, will affirm and posit himself (Levinas 2001:212).

Between normative ethics and western rationality both Kierkegaard and Levinas propose an alternative ethical theory. Levinas sets out some themes common to both philosophers when he states;

> Responsibility in fact is not a simple attribute of subjectivity, as if the latter already existed in itself, before the ethical relationship. Subjectivity is not for itself; it is, once again, initially for another (Levinas 1985:96).

Both share a critique of philosophy which argues that in the name of autonomy, philosophy subordinates the individual to the impersonal (Weston 1994). Kierkegaard was responding to Hegel's philosophical system. In the *Concluding Unscientific*

[87] For Levinas the relation with the other is not symmetrical; '[…] in the relation to the face, it is asymmetry that is affirmed; […] (Levinas 2001:166)'.

[88] In his preface to 'Emmanuel Levinas; Basic Philosophical Writings' Peperzak writes; 'The expression *il y* a translates the German *es gibt* (there is), but receives a very different interpretation from Heidegger's: rather than the generosity of a radical Giving, *il y a* is the name of a dark and chaotic indeterminacy that precedes all creativity and goodness (Levinas 1996: ix)'.

Postscript Kierkegaard writes with a great sense of humour regarding Hegel where he proposes;

> If a dancer could leap very high, we would admire him, but if he wanted to give the impression that he could fly - even though he could leap higher than any dancer had ever leapt before - let laughter overtake him. Leaping means to belong essentially to the earth and to respect the law of gravity so that the leap is merely momentary, but flying means to be set free from telluric conditions [89], something that is reserved exclusively for winged creatures, perhaps also for inhabitants of the moon, perhaps-and perhaps that is also where the system will at long last find its true readers (Kierkegaard 1992a: 124).

Although Kierkegaard was specifically responding to Hegel, Levinas was also responding to a philosophy which was *totalising.* It is perhaps useful here to quote a précis of Hegel's thought before considering the alternative proposed by Levinas and Kierkegaard. In the preface to *Phenomenology of Spirit* Hegel wrote as one of the aims of his work;

> 5. The true shape in which truth exists can only be the scientific system of such truth. To help bring philosophy closer to the form of Science, to the goal where it can lay aside the title '*love* of knowing' and to be *actual* knowing - that is what I have set myself to do […] To show that now is the time for philosophy to be raised to the status of a Science would therefore be the only true justification of any effort that has this aim, would indeed at the same time be accomplishing it (Hegel 1977: 3, 4).

[89] 'of the earth as a planet'

Levinas challenges this view of truth and he challenges the previous concepts of ethics. For Levinas, Western philosophy and civilisation has an approach which reduces everything to be rationally ordered and manipulated. This analysis is performed in the framework of the term the 'ontology of power'. In centring the theory on the primacy of the inter-human relation, Levinas reverses the power relation in social and political systems since Plato. The next section is going to explore the extent to which individuals perceive freedom to act ethically in the concept of *Kinesis* as outlined in the introduction to the previous chapter.

Kinesis

It will be recalled that Kierkegaard applied the concepts of potentiality, and actuality, with *kinesis* as category of transition. It is then this process of actualization that will be considered in this section.

The legal cases selected so far have explored the jurists' decision making; the next Case (Denise Lynn Merelie v. Newcastle Primary Care Trust and Denise Lynn Merelie v. Newcastle Primary Care Trust & Others'(2006 WL 1732530, 2006 1732530 (QBD) [2006] EWHC 1433) discusses the dynamics of relationships in witnessing poor clinical care.

This Case was brought to court by the Claimant (Denise Lynn Merelie), who was employed by Newcastle Primary Care National Health Service Trust as a senior dentist, until her dismissal in May 2001. Although the pre-court history is complex (Please see Appendix 3.), it was her dismissal which triggered the Claimant to take the case to

court. Where, commonly it would be the patient who would directly bring a case of negligence to court, in this Case the Claimant has brought two actions against Newcastle Primary Care NHS Trust and a large number of employees and managers within the Trust.

The first action is a claim that the Trust broke its contractual obligations to the claimant. Specifically, this argument alleges a breach of the contractual duty of trust and confidence laid out in the 'Malik duty' (Malik [1998] AC20). The breeches refer to the Trust not following its own grievance procedure when the claimant lodged a complaint about her immediate manager, Mr Ferguson in October 1999. Also, it refers to the Trust not investigating the allegations made about the claimant.

The second action is a claim in negligence where the Trust owed the Claimant a duty of care as an employee, and had '[…] breached that duty by unreasonably exposing her to a foreseeable risk of injury (Paragraph 9, Page 5 [2006] EWHC 1433)'. This refers to the Trust knowing that the Claimant was vulnerable to stress due to her sickness record in 1999, and therefore should have foreseen that any allegations which were made against her would cause her injury.

Where at first sight it may seem the essence of this case is the negligence on behalf of the Trust to discharge its 'duty of care' to the Claimant, in actual fact the case begins when staff raise their concerns about the Claimants behaviour towards patients and other members of staff. For in November 1999, two dental colleagues (Ms Nagaj and

Mrs Welbury) wrote to Mr Ferguson as manager about the Claimants unprofessional conduct. Mrs Welbury explains in her letter:

> All the incidents reported about this dentist since August 1999 have involved members of staff within several departments of the Trust, except for the complaint I have received from South Benwell [Primary] School (Paragraph 105, P.33 [2006]EWHC 1433).

Equally Ms Nagaj raises her concerns for the patients' safety where she writes;

> As the problem has involved Trust staff outside our department and indeed people outside the Trust I would like to be assured this is being addressed by a suitable person, to safeguard our patients (Paragraph 106, P.34 [2006] EWHC 1433).

Then in March 2000, four Dental nurses lodged a complaint under the formal Grievance procedure against the Claimant. The substance of these complaints was about the way the Claimant related (or rather failed to relate) to the patients and their Carers. Insight can be gained form the evidence provided by Mrs Fawcett (Dental nurse) who explains the Claimant; '[…] did not come across as overly sensitive' with patients. She; '[…] had no emotional involvement with them, she simply did the job" (Paragraph 39, p.13 [2006] EWHC 1433)'. Another dental nurse (Mrs Falkous), observed that the Claimant; '[…] never spoke to patients and was not warm towards them; patients sometimes commented that she was miserable (Paragraph 39 p.14. [2006] EWHC 1433)'. The written concerns from the dentists and the evidence from the nurses are all the more significant when it is realised that the patients consist of principally, schoolchildren, the elderly, mentally ill, and patients with a dental phobia.

One of the main features in this Case is the way in which the Claimant related to other members of staff, and to patients. In the caring professions, such as nursing, medicine, social work, Allied Health Professions (predominantly Physiotherapy), and dentistry, the 'use of the self' is crucial in providing sensitive, individualised care. The research relevant to this area includes the group of concepts; *Therapeutic Self* (Peplau 1988), *Emotional labour* (Hochschild 1983, Strauss et al. 1982, Fineman 1993), *Social intelligence* Thorndyke (1937), *Emotional intelligence* (Thorndyke 1920, Salovey and Mayer 1990, Goleman 1995, Cartwright & Pappas 2008) and *Moral distress* (Within Nursing; Jameton 1984, Wilkinson 1989, Corley 2002, Hanna 2004, Hardingham 2004. Within medicine; Hillard 2007. In Psychiatry; Austin 2008. And Social Work; O'Donnell 2008). Some researchers are working in more than one area, and it is worth noting that the work by Mayer et al. (2000, 2001, and 2002) is attempting to measure Emotional intelligence from two differing aspects, which is contributing to conceptual confusion.

Strauss et al. (1982) was the first to report that there was more to medical work than the physiological core and posited the idea of 'sentimental work'. Fineman (1993) also identified that medical work contains *emotional zones*. This work has been further developed into the first definition of *Emotional intelligence* provided by Salovey and Mayer (1990:189) as being; '[…] The ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions'.

In the legal case the evidence indicates that the claimant was in what Kierkegaard would consider *despair*. Due to her inability to bring the two opposing factors together, her Self was in an imbalance by choosing one factor more than the other. In this existential position, she was not yet a self. This will be discussed using a number of examples from the case. This will be performed by moving from the overall, macro issues, towards the way this was manifested in caring for individual patients, at the micro level.

One of the most arresting features of this case is the case history (Please see Appendix 3). On numerous occasions the claimant has been informed of the facts being held against her from multiple perspectives, and she remains indifferent to these facts. This is a common feature which can be traced from her colleagues, through the NHS organisation and into the legal system, culminating in the claimant ignoring the judges ruling on refusing an appeal. In concluding the case on the 11th of April 2006, Mr Justice Underhill stated;

> The Claimant has applied for permission to appeal. I refuse that application. My decision on her claims has been based essentially on findings of fact and I do not believe that there is a reasonable prospect of those findings being overturned on appeal (Paragraph 202. p.61EWHC 1433).

Yet, on the 2nd of March 2007, the claimant appealed to the Supreme Court of Judicature Court of Appeal, where nine claims were set out as grounds of appeal against the previous judge ([2007] EWA. Civ 171).

Both Kierkegaard and Sartre would see the claimant as transcending her *facticity*, in favour of *possibility* and *freedom* (transcendence). Kierkegaard would consider the claimant's (Denise Merelie) *despair* as due to her negative unity in choosing the infinite over the finite, and that Denise had not discovered this *unconditional commitment* which would help her bring the two opposing factors together. This point is important to the philosophy of both Kierkegaard and Sartre as without some requirement for equilibrium the criticisms of existentialism providing a radical freedom would be difficult to answer. Sartre responds to the same challenge by explaining that when the individual chooses, they are choosing for the whole of humanity.

King clarifies Kierkegaard's position on this way of relating, but also adds to it by presenting Nietzsches' view where he states:

> For Kierkegaard the existing individual does not, as with Nietzsche, unfold solely within immanence, within the closed limits of the finite, but is from the beginning grounded in transcendence, and only in relation to this higher Being can he be understood in his self-hood. It is the individuals' way of relating to these two poles of reference, the finite and the infinite, and within them to himself, that form the basis of his particular mode of existence. It is the observation, not only as a thinker but equally as a poet, of the various forms this relating may take that characterize the originality of Kierkegaard's re-examination (King 2005:30).

This point of departure for Kierkegaard from Nietzsche, and indeed, Kierkegaard from Sartre is not only important for this claimant, but also for any ethical theory. All of the existential writers emphasize *facticity*, which becomes crucial when individuals start to consider what they *ought* to do in any given ethical situation. For this question is

fundamentally tied by how the individual views their transcendence in deciding what they *can* do. That is, how they perceive their freedom.

In the Case summarised here a number of working relationships had deteriorated. The first involved the Claimants line manager. This can be seen in the case transcript where the claimant claimed; '[…] An unparticularised allegation of sexual harassment; and allegation that Mr F. hounded the Claimant relentlessly, constantly complaining and criticising everything she did (Paragraph 10, p. 6 [2006] EWHL 1433.)'.

Crucially, the Claimants relationship with her patients had deteriorated. There are witness accounts which state the claimant:

> […] Did not come across as overly sensitive with patients; "had no emotional involvement with them" and "never spoke to patients and was not warm towards them: patients sometimes commented that she was miserable" (Paragraph 39. pp.13 & 14 [2006] EWHL 1433.).

The dental nurses had observed the behaviour towards patients, had experienced it first hand, and had refused to work with the dentist. Finally, the Claimants relationship with the organisation (Newcastle Primary Care Trust) deteriorated as she escalated her complaints through line management, culminating in a letter to the Chief Executive of the Trust.

The fact that the relationships had been deteriorating over a significant period of time is useful in observing how individuals and the organisation – as embodied in management

- responded. A philosophical analysis of these relationships from a Kierkegardian perspective would provide an overarching framework which leads to the consequences of poor relationships. Kierkegaard will also help in drawing out some of the problems in adopting Existentialism in its entirety.

Kant's moral philosophy states; 'Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end (Kant.1997a: 91)'.Where Kant was concerned with universal laws, and Existentialism concerned with the particular, there are similarities here in that both demonstrate a concern in caring for the self , and Kant attached value to ends in themselves (*persons*) and; '[…] Only a relative value as means and are consequently called *things'* (Kant 1997a: 90, 91). In the court transcripts it appears as if the dentist had become ethically desensitised and was predominantly existing in the *Aesthetic* sphere of existence, which –as a dynamic process-puts a distance between the self and the patients. For Kierkegaard this can happen so subtly the it may occur without the individual self noticing; 'The biggest danger, that of losing oneself, can pass off in the world as quietly as if it were nothing: every other loss, an arm, a leg, five dollars, a wife, etc. is bound to be noticed' (Kierkegaard 1989:62,63).

So far this analysis of the court transcript has explored the dentist's relationships with other people, but Kierkegaard's analysis would also include the organisation. Sartre departs from Kierkegaard in the crucial aspect in that he believes that freedom is an absolute end in itself. For Sartre, *authenticity* becomes the fundamental ethical category as individuals appreciate their status as radically free. Kierkegaard's overall structure of

being is outlined in three stages of the *Aesthetic, Ethical* and finally *Religious*. It is in the *Ethical* stage that the individual discovers the bankruptcy of ethical codes. In fact it is; […] Dangerous precisely because it is the category of the crowd, the community (Vardy 1996:52)'. Unlike Sartre, Kierkegaards' fundamental ethical stage is the *Religious* where the individual comes to an end of self-reliance and discovers selfhood in an ethical model. Rather than a leap into oblivion this model is based upon one major law; *non-preferential love*[90] (Care).

Any retrospective analysis has the privilege of being able to isolate rigorously the written law (law 'as ought') from the law as practiced (laid down, 'as is'), and any moral judgment can similarly be suspended until the legal facts are elucidated. When such a suspension of judgment is applied to the clinical decision making (of nurses, doctors, dentists, and Allied Health Professionals) similar ethical issues are uncovered when the process is applied to the legal system (of expert witnesses, and jurist's decision making), the foundational one being freedom. That is freedom within the two predominant ethical frameworks of a consequentialist and non-consequentialist approach. This premise will be explored by building upon the previous cases with the introduction of another patient, Mr Harry Coleman.

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[90] Love is an important aspect in Kierkegaard's work , along with suffering. It is linked to the existential spheres where in the esthetic the individual has a self love, but as the individual moves to the ethical and the religious they develop a self for the other. There is a detachment from the world as external objects, and a move inward to values which transcend the immediate. Kierkegaard also contributes to epistemology by distinguishing between the differing forms of truth; the truth as knowledge, and the truth as love. Kierkegaard is able to consider philosophical problems related to existence and ideas, through the concept of love. He brings together love *(philo)* and wisdom *(sophia)* (Carlisle 2006:156).

Moral and legal responsibility

The Case of Mr Harry Coleman ([2004] EWHC 2931 (Admin), 2005] EWCA Civ 1172) raises questions regarding the integration of ethics and law, and indeed if they are separate, independent, frameworks. Perhaps with the main question being; 'Is moral responsibility divorced from notions of legal responsibility?'

Mr Coleman, who was an eighty-three year old gentleman, was admitted to Luton & Dunstable Hospital in 2003, for the removal of gall stones. During the procedure for removing the stones (Endoscopic Retrograde Cholangio-Pancreatography, sphincterotomy and stone extraction (ERCP)), it was found at post-mortem that the consultant surgeon had caused; '[…] An oval full thickness tear of 0.9 cm maximum dimension on the anterior surface of the duodenum (Line 16 [2004] EWHC 2931 (Admin))'. It was this traumatic perforation of the duodenum which caused peritonitis and ultimately Mr Coleman's death.

Other relevant clinical details include the fact that the nurses allowed Mr Coleman to suffer pain for three and a half hours while they waited for the house officer to respond to his bleep;

> At 18.30 the nurses noted that he was complaining of abdominal pain. The surgical house officer was bleeped, but did not see him until 22.00. At that time Mr Coleman was noted to have been complaining of abdominal pain since his ERCP ([2004] EWHC 2931 (Admin): Line 7).

Again, during the night Mr Coleman's clinical observations documented his deteriorating condition, and when the nurse informed the house officer at 5.20 am, the doctor did not attend;

> At 05.20 there is an entry in the nursing notes that he was complaining of pain and had a distended abdomen. His oxygen saturations were dropping. The house officer was informed but did not attend at that time ([2004] EWHC 2931 (Admin): Line 10).

More than three hours later, at 08.30am the doctors were informed that Mr Coleman's blood pressure had fallen to 90/60 mmHg., his pulse had increased to 110/min and his oxygen saturations were 88%. At 9am the doctors visited Mr Coleman and discussed the possibility of surgery for a perforated bowel. Since 1830 hours the previous night Mr Coleman's pulse had been increasing, his blood pressure falling, respiratory rate increasing, and urinary output decreasing to less than 20mls per hour. These are all the cardinal signs of a patient's clinical condition deteriorating. In this situation the nursing and medical staff have a duty of care to the patient, which includes a duty to implement prompt care.

It is surprising to read in detail of how, especially the nurses in this case, documented their lack of action in the sight of objective knowledge. For both Kierkegaard and Sartre this would be non-reflective being. In Kierkegaard the pre-ethical stage of the *Aesthetic* corresponds to a life of immediacy where the individual is concerned only with their socially determined identity. As outlined in the introduction this would be in Sartre's ontology *being-in-itself.*

The scenario from a Levinasian perspective reveals the nurses as not hearing the *call* of the other. Not experiencing being the others hostage, of the asymmetrical *height* in the face of the other, and therefore not being moved to act.

This is why for Kierkegaard:

> Viewed ethically, the actual is higher than the possible. It is the very disinterestedness of possibility that the ethical wants to annihilate by making existing the infinite interest (Kierkegaard 2009c:268).

Following his death one of the doctors informed the coroner, who in turn ordered a post mortem. Mr Coleman's daughter (Mrs.Rita Goodson) thought that her father's death may have been caused by clinical negligence and requested that the Coroner should conduct an enquiry in accordance with the requirements of Article 2 of the *European Convention on Human Rights* (ECHR[91]), which requires an independent medical expert to assess the treatment given to her father. The legal essence of the case is that Mrs Rita Goodson (claimant) sought judicial review when the coroner (defendant) refused two applications concerning the inquest which were that; firstly to conduct the inquest as an investigation for the purposes of the Human Rights Act 1998, Schedule.1 Part I Article.2[92] (Human Rights Act 1998), and secondly to appoint an independent medical expert to be involved in the inquiry.

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[91] The content of the ECHR Article 2 and the Human Rights Act 1998 Schedule.1 Part I Article.2, are the same. The 1950 ECHR was incorporated into the HRA.

[92] '1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law'.

The decision to engage article 2 of the ECHR is at the discretion of the coroner. One of the areas of practical guidance is from Lindsay and Astill (Lindsay and Astill 2004: 4) where they explain:

> He [the coroner] should consider where the death in question is likely to appear on the spectrum of possible Article.2 violations: from murder at one end to plain negligence at the other.

At this juncture in the transcript it is worth noting two levels of argument. At the superficial level there is a discussion about how just the coroner's decision making was. More significantly is the larger discussion regarding constitutionalism. The claims against the coroner will be considered before exploring the more fundamental questions regarding constitutional law.

The notable points about the trustworthiness of the coroner's investigative approach are the following; The coroner had no medical qualifications but chose not to involve any expert witnesses other than the Consultant surgeon (Miss Chesly-Curtis) and Senior Registrar, who were both involved in the surgical operation performed on Mr Goodson. These facts can be evidenced from Paragraph 29 in the court transcript:

> 29. In relation to each basis it is submitted that the coroner, who is not medically qualified, was wrong to refuse to seek independent medical evidence in reliance solely upon his own uninformed view that there was no ground for considering that the medical personnel involved might have been negligent and that he trusted them to give an objective opinion on their area of expertise as to the

> adequacy of their own treatment which led to Mr Coleman's death ([2004] EWHC 2931 (Admin):paragraph 29).

Additionally, the Consultant surgeon provided a report which included statistics on the morbidity and mortality associated with the surgical procedure, but there were no references to support these figures. During the court case the coroner's legal team submitted the above two aspects as crucial evidence:

> However, in this case, the statistical evidence coupled with the clinical judgment of more than one Specialist, the facts of the case, the medical text-books and common sense, do not in any way lead towards negligence…([2004] EWHC 2931 (Admin):paragraph 25.2).

In other words, the two individuals involved in performing the operation provided expert evidence in the case against them.

Another area of potential bias is where the coroner relied upon the forensic pathologist. In the court transcript the inconsistencies in the coroner's evidence is highlighted where it states:

> In his written reasons he acknowledged that he could not rely on the pathologist, Dr Calder, to give evidence "beyond his remit" (though in his witness statement he refers, inconsistently, to Dr Calder as "very experienced in carrying out autopsies in relation to hospital deaths and recognising signs of negligence). He was otherwise relying on the evidence of the very witnesses whose conduct was in question. He denied himself the independent evidence which could have enabled him to decide whether or not there was any sign of clinical negligence. … ([2004] EWHC 2931 (Admin): paragraph 29).

The final, but perhaps the most fundamental error in the coroners approach relates to whether article 2 of the European Convention on Human Rights (ECHR) would be engaged by Mr Goodson as a patient within an NHS Trust hospital. The coroner thought that the case should not be considered for investigation because article 2 was not engaged. The rational he provided for this was; 'In this case I am firstly not convinced that the Luton & Dunstable NHS Hospital Trust is a State Body or an Agent of it ([2004] EWHC 2931 (Admin): paragraph 25.1)'. Effectively, the coroner had denied the deceased's family the right to have their fathers death investigated as recognised within the ECHR. This contradiction and lacuna was later explicitly accepted where it records in the legal transcript:

> i) The Luton and Dunstable Hospital NHS Trust is a public authority within s.6 of the Human Rights Act 1998. This is now accepted on the coroner's behalf, although he expressed a different view in his written reasons ([2004] EWHC 2931 (Admin): paragraph 33.1).

The dialectic above is in many respects a veil over a more significant argument which can be uncovered in the defence provided by Mr Burnett on behalf of the coroner. Almost buried in the totality of the transcript is this one sentence, which said en passant could be readily missed, and yet it changes the whole legal framework through which the coroner is viewed:

> 36. Mr Burnett QC emphasised that the coroner was represented before this court for the purpose of providing assistance to the court rather than to defend the particular decision([2004] EWHC 2931 (Admin): paragraph 36).

As a consequence of this perspective the coroner became protected in his status as ‘providing assistance to the court’. So far the analysis has uncovered a number of weaknesses in the investigative approach taken by the coroner, and a legal manoeuvre executed to limit cross examination of the coroner’s investigative rationale. The previous discussion from Kant on the *purposiveness* again seems to be relevant here in considering how the patient, coroner, and law are viewed in relation to the desired *telos.* Of equal importance are the grand themes from Kierkegaard, Sartre, and Levinas regarding *kinesis* where the individual lawyers and jurists are deciding upon the ethical by the decisions they make. These themes will now be considered in the main argument put forward by Mr Burnett when advocating on behalf of the coroner.

The argument set out by Mr Burnett is of great importance to this thesis due to the way it makes explicit the link between law and morality. The same line of argument was also used in Rogers previously, and Khan in the next section.

This argument could look deceptively reasonable *prima facie.* However, it gathers authority when it is discovered that this argument is linked through legal principles laid down in a famous case simply referred to as *Wednesbury*. From the transcript it can be established that the coroner made his judgement - that there was no negligence - based upon *Wednesbury:*

> 43. In keeping with the coroner's general stance before the court, Mr Burnett did not address detailed submissions in defence of the particular decision. He pointed out, however, that the coroner took the view, for the reasons given by him in writing, that there was no reason to believe that there was or

> might have been negligence. Mr Burnett submitted that whether the coroner was entitled to reach that view on the particular facts was to be determined on Wednesbury principles. The mere fact that the possibility of negligence had been raised by the family was not enough to require the coroner to retain an independent medical expert. It was a matter for his judgment ([2004] EWHC 2931 (Admin): paragraph 43).

Wednesbury is a shorthand term used by lawyers to refer to a prominent legal case (Associated Provincial Picture Houses, Limited v Wednesbury Corporation. [1948] 1 K.B. 223.) that set out the standard for unreasonableness in administrative law. It is also know as *Wednesbury principles*, *Wednesbury unreasonableness*, and *Wednesbury grounds*. While the content of the case was about a local authority allowing a cinema to open on a Sunday - on the condition that no children under the age of fifteen years of age were admitted - the judges ruling developed the doctrine of 'reasonableness'. In his judgement Lord Greene explained:

> Once that question is answered in favour of the local authority, it may be still possible to say that, although the local authority have kept within the four corners of the matters which they ought to consider, they have nevertheless come to a conclusion so unreasonable that no reasonable authority could ever have come to it. In such a case, again, I think the court can interfere. The power of the court to interfere in each case is not as an appellate authority to override a decision of the local authority, but as a judicial authority which is concerned, and concerned only, to see whether the local authority have contravened the law by acting in excess of the powers which Parliament has confided in them ([1948] 1 K.B. 223: Line 234).

This doctrine clearly has real implications for the current case being discussed, but more importantly as contributing to a philosophy of law. With contemporary modern

management there is a focus upon efficiency and effectiveness in financial terms. So resourcing dilemmas have become commonplace as adjudication problems within law. First the actual defence set out on behalf of the coroner will be discussed, and then attention will be given to the doctrine as part of legal theory.

Although the argument set out by Mr Burnett QC is lengthy it succinctly draws together a number of areas of diverse legal theory:

> The court should be aware of the implications of the position for which the claimant is contending. At present, independent experts are retained in a very small proportion of inquests into deaths in hospital (some 5-6% of the total in the coroner's own experience, though practice varies across the country). The Report of the Fundamental Review in June 2003 estimated the total cost of the whole coroner service at about £71.4 million per annum. If independent experts had to be retained in all inquests involving hospital deaths, that cost would rise very substantially. Decisions have yet to be taken on the Report of the Fundamental Review and, as was recognised in Middleton (para 34), those decisions will take into account the relevant policy, administrative and financial considerations; and, pending those decisions, the existing scheme must be respected save to the extent that a change is required in order to achieve compatibility with the Convention. The court should not be seduced into achieving by judicial activism a change that is properly a matter for legislation. Moreover, if the claimant's arguments in relation to deaths in hospital were accepted, the same might apply e.g. to deaths in care homes and to other areas of state regulation ([2004] EWHC 2931 (Admin): paragraph 36).

With the four aspects of Mr Burnett's argument culminating in this 'Flood-gate argument', warning to the court, it is easy to lose sight of what it is in response to. Simply put, it was Mr Coleman's daughter requesting on behalf of the family, that the

inquest should be conducted for the purposes of article 2 of the ECHR. She had also requested an independent medical expert to review the treatment given to her father. When the coroner had refused these requests, Mrs Goodson wanted to challenge the lawfulness of the coroner's decision to refuse these applications. It is worth restating the focus of the family's concern before considering Mr Burnetts defence statement and the wider political, economic and philosophical context of this legal argument.

The line of argument set out by Mr Burnett has an established authority. Certainly in *Wednesbury*, but also in the Diceyan model of sovereignty (1914), and in the work of Michael Polanyi (1999) who in turn influenced Lon Fuller (1978). In the next chapter this legal theory will be discussed in relation to Kierkegaard's view of community and politics. Dooley expresses this where he argues:

> …the one abiding concern throughout is how to release the ethical from the sclerosis of dogma so as to keep it focused on what is essential and primary in all ethical considerations, that is, the single individual (Dooley 2001:xix).

At present the focus shall remain on the legal discussion, and in tracing the development of adjudication will perhaps identify the temporal flux which is unavoidably part of *kinesis.*

Interestingly, Dicey (1914) expressed the classical definition of sovereignty which would be similar to Kierkegaard's view of polity. That is in the Diceyan model of sovereignty there is a belief in limited government and minimum state intervention.

Similarly, Michael Polanyi has influenced economic and political theory especially through his book *Logic of Liberty: Reflections and Rejoinders* (Polanyi 1999). It is within this book that Polanyi explains the concept of Polycentricity. In considering the relationships between producers and purchasers Polanyi develops a regular polygon framework, which when stretched along its vertical axis reveals how all of the interlocking angles are affected. From this mathematical model Polanyi went on to propose that polycentric problems comprise of a large and complicated web of interdependent relationships. When change occurs to one relationship, it produces an incalculable series of changes to other relationships (King 2008). Polanyi influenced the work of Lon Fuller who was a philosopher of law. Fuller developed the concept of polycentricity as discussed by Polanyi and applied it to the process of adjudication (Fuller 1978). Crucially, Fuller thought that polycentric disputes were non-justiciable (Fuller 1978, Allison 1994, King 2008).

Analysis of the legal theory so far suggests a non-interventionist approach would be taken in polycentric cases on resource allocation issues. Syrett (2000) found that in reviewing recent cases involving resource allocation within the NHS, there was near universal refusal to intervene by the courts. The Goodson case had polycentricity due to the interested relationships involving the coroner's office, and the National Health Service. Mr Burnett appears to appreciate this in emphasising the impact this decision could have if it were to also include the Independent sector with care homes. A full blown discussion of the relationship between the individual and the state will be carried out in the next chapter. In the meantime the discussion will continue with another two cases.

Potentiality And Actuality

The two further cases which have influenced coronial law are that of Middleton ([2004] WL 343872) and Khan ([2003] EWCA Civ 1129). In Middleton the Court of Appeal rejected the distinction between individual and systemic neglect in relation to his death while in custody. However it did extend the role of the coroner in an inquest from only exploring the 'by what means?' did the death occur, to 'by what means and in what circumstances?'

The exploratory legal framework applied in the Goodson case was also influenced by Khan. This case provides a useful comparison in exploring the legal process in operation as the clinical negligence is similar, but the legal outcome is different. In the case of Khan a three your old girl (Naazish) was being cared for by a nurse providing haemodialysis. The nurse omitted to take regular blood gas analysis of potassium, and also omitted to shake the dialysate bag of fluid to ensure thorough mixing of the potassium. The outcome was that Naazish received a fatal dose of potassium which caused cardiac arrest and death. In this case the court found that the coroner's investigations had not been sufficiently detailed to enable the procedural (adjectival law) obligation under article 2, to be fulfilled.

In the two cases of Goodson and Khan the role of the coroner is to implement the Human Rights Act which incorporates the ECHR. As outlined above it is Article 2 (The right to life) which is the relevant statute. In law the obligation upon the state is to protect life, to put in place effective legal systems to prevent offences against

individuals. Within healthcare the requirement to protect life is supported by professional standards via the General Medical Council (GMC), Health Professions Council (HPC), and the Nursing and Midwifery Council (NMC). The House of Lords emphasised the coroner's role in Middleton where they stated;

> In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that his inquest is the means by which the State will discharge its procedural investigative obligation under Article 2. (Line 4 [2004] WL 343872).

The crucial point is that in Goodson the coroner refused to carry out an independent inquiry citing the fact that it was a case of 'simple negligence'. In comparison, the Khan case was one of 'Gross negligence'. For the purpose of justice the coroner has a primary role in starting the legal process. It is also worth noting that the coroner in the Goodson case was not medically qualified which may contribute to how effectively clinical details can be validated. The only staff to be interviewed were those involved in the operation, and no Expert witness was called for an independent opinion.

One of the intentions of the HRA was:

> To enable individuals to use the UK courts to prevent and remedy the misuse of public power which is the primary purpose of incorporating the ECHR (Klug and Stramer 2005:1).

There have been, however, problems where the convention conflicts with existing law, or where changes in society have challenged the implementation of the ECHR. An

example here would be on aspects of liberty and laws regarding terrorism. Klug and Starmer explain some of the detail where they state:

> Confounding early assumptions that declarations of incompatibility would be infrequent, the higher courts have issued 17 in five years, of which 10 are still standing (Klug and Starmer 2005:3).

The history of the introduction and implementation of the HRA outlines the ongoing challenges in attempting to protect individuals' rights (Klug and Starmer 1997, 2005, Sparks 2008).

The legal responsibility to protect individual rights is problematic as outlined above, and continues to be so, especially when jurists and coroners have financial consequences to consider. Within a moral framework it is striking to see the behaviour of jurists, coroners, medical and nursing staff when considering the rights of a patient. When Naazish Khan died the consultant anaesthetist omitted to inform the family of the overdose of potassium.

Lord Justice Brooke explained in the introduction to the case that:

> A doctor at the hospital discussed the situation with her parents at some length, but it is said that he regarded the very high potassium levels [18.9mmol/L[93]] as an artefact and made no reference to them at all (Paragraph 8 [2003] EWCA Civ 1129).

[93] The potassium level has been added to the quotation. The normal therapeutic level would be 3.5mmol/L-5mmol/L, and it is common knowledge in clinical practice that anything out with this range (Hyperkalaemia and Hypokalaemia) results in cardiac arrhythmias/cardiac arrest.

Due to the clinical staff at the hospital omitting to inform the coroner of the high potassium level, the cause of death was recorded as one of cardiac arrest and a malignant tumour of the lymph nodes. Naazish was buried within 24 hours of her death as in accordance with the family's Muslim faith. At great distress to Mr Khan the police investigation required Naazish's body to be exhumed for post mortem. The pathologist carrying out the post mortem (Dr Millroy) found:

> Taking the findings of high potassium at collapse, combined with the post-mortem findings and the experiments performed on 25th November 1999, described by Professor Forrest, in my opinion death is consistent with potassium poisoning (paragraph 11 [2003] EWCA Civ 1129).

The appeal committee in the House of Lords considering the case of Middleton had a discussion regarding 'system' negligence and 'individual' negligence. Their conclusion was:

> […] For the purpose of vindicating the right protected by article 2 it is more important to identify defects in the system than individual acts of negligence. The identification of defects in the system can result in it being changed so that suicides in the future are avoided. A finding of individual negligence is unlikely to lead to that result (paragraph 88[2004] WL 343872).

This is an important feature which occurs within all of the professions (nursing, medicine, law) and at the differing health and legal hierarchical system levels.

When the nurse is considered in the Goodson case, the nurse, nursing Sister, and consultant anaesthetist in the Khan case, they all live in this tension between the

'individual' and the 'system'. Each had to decide what to do, given the facts of their situation.

In the Denise Lynn Merelie case above the potential of losing oneself can be recognised as Kierkegaard proposed:

> Once the will begins to have half an eye for the outcome, the individual begins being immoral-the will's energy slackens, or is developed abnormally into an unwholesome, unethical, mercenary hankering that, however great its accomplishment, does not accomplish the ethical: the individual insists on something other than the ethical itself (Kierkegaard 2009c:112)

Yet this point has great significance as Sartre considers the role of consciousness in relation to the I. In tracing the role of consciousness from Descartes' 'I think, therefore I exist' Sartre crucially parts company with Kant where he explains; 'The problem of the critique is a *de jure* problem; thus Kant affirms nothing about the *de facto* existence of the 'I think' (Sartre 2004:2)'. The Self is out there in the world, like the self of another. It is more than the self-consciousness as outlined by Descartes; it is an ongoing project in the world. Sartre is in accord with Kierkegaard in considering consciousness as unifying itself;

> It is consciousness that unifies itself, concretely, by an interplay of 'transversal' consciousnesses that are real, concrete retentions of past consciousnesses. In this way, consciousness continually refers back to itself: to speak of 'a consciousness' is to speak of the whole consciousness, and this singular property belongs to consciousness itself, whatever its relations with the I may in other respects be (Sartre 2004:7).

This constituting aspect of consciousness has important implications for the way in which professionals view their *'facticity'*. The nurse in the Goodson case diligently documented the clinical picture of a patient dying in front of her eyes while patiently waiting for the doctor to respond to his bleep. In a similar fashion, the nurse, nursing sister and consultant anaesthetist in Khan withheld vital information about the Hyperkalaemia as causative in the death of Naazish. This concept is discussed by Sartre (2000) in *Being and Nothingness* when he considers the concept of *bad faith* with the use of vignettes.

Conclusion

The legal system, and Case law in particular, have a number of vying pressures to contend with, as law as distributive and corrective justice. Jurists' decisions regarding claimants of clinical negligence invariably include distributive justice. This has been and remains a significant factor in considering the ends of justice. It has not been possible to obtain an overall accurate financial costing in terms of clinical negligence litigation. The devolved parliaments, creation of NHS Litigation Authority in England, and the fact that many cases remain live or open, make it difficult to calculate an overall accurate sum. However, the statistics already discussed give an insight into the cost factor. The case of Denise Merelie is a good example of some of the costs involved. Not just financial, but also in staff time attending legal proceedings, and the cost to the Trusts corporate image, or impact upon its branding strategy. What originally started out as a staff grievance within Newcastle Primary Care Trust, in October 1999, has now been discussed in various courts on four different occasions, the most recent being in April of 2009. The continual evolution of the legal system and the relevant area of

tort law ensure distributive justice will remain an end pressure upon the jurists' decision making process. One of the current challenges within current legal reform, -as expressed through the NHS Redress Bill (House of Lords 2005), and the transition from the House of Lords to the Supreme Court- will be encouraging health professionals and NHS Trusts to admit to clinical negligence as soon as it occurs. This will be challenging as it is counter to the philosophy of the quasi-market economy within which the NHS operates. As the cases have demonstrated the Trusts are reluctant to accept charges of negligence, and will challenge costs even once they have been found negligent in law. An example of this would be where the NHS Trust was found negligent in causing the death of baby Elliot, but after the hearing the NHS Trust appealed against the judges decision regarding the costs (Brindley V Queen's Medical Centre University Hospital NHS Trust [2005] EWHC 2647 (QB)). The appeal was dismissed but even at the end of the legal process, there seemed to be no acceptance of responsibility by the Trust for caring for Elliot and his mother. Legal procedure requires non legal factors to be bracketed out of the discussion. The NHS Trust as Defendants must also comply with this approach, and also continue to compete within the health market. Both factors have an overall dynamic of de-robing the human of their subjectivity.

The 'duty of care' concept within tort law defines relationships. Through various tests it can establish if a relationship exists, and if it does exist, the resultant standard of care owed. Queens Council, William Norris (2009) provided the memorable examples of where no duty exists when the bystander observes the nonchalant walker heading towards the cliff, or where the pedestrian is flattened by a lorry after failing to look

right. This necessary defining, limiting, and quantifying of the duty sets the threshold for measuring what is considered negligent, or what is legal and illegal. Such a quantified threshold however, can be used to decide standards of care within health care, and also as a benchmark in defence litigation. At the professional level and the strategic NHS Trust level an optimal level of conduct can then be calculated and translated into professional regulation and clinical standards of care. The economic cost is calculated on the minimal cost of care balanced against any potential litigation. Young (Young et al.2006) explains that in a range of potential defences in negligence, the lack of a breach of care is the most cost effective defence. While potential litigation can have a normative influence upon relationships of care, it remains at a minimal standard, and the challenge is in forcing a duty *to* care. Perhaps this is best seen in the case of Michelle Anne Brindley ([2005] EWHC 2647 (QB)) where Professor James was chair of the working group for standards developed by the Royal College of Obstetricians and Gynaecologists entitled *Fetal Guidelines for Screening Diagnosis and Management*. During the case it was established that he had failed to implement his own standards. In the same case Dr Twining said it was not his practice to make records of his discussions with patients. He accepted that this was poor practice, but he did not have time to make entries of this kind in the patients' records.

Definitions of ethical health care require sensitivity to the historical context. Most of the cases considered have been post-NHS reforms, in the context of the quasi market economy. Yet it had been striking to note that both Lord Atkins' legal principle of neighbour and Levinas's philosophy is founded upon the example of the Good Samaritan. Organised care is historical, but care of the Other is transhistorical and

therefore infinite. The definition is based upon the telos. One is calculated on finance, the other stands outside of time and resource considerations. The subtle difference is seen in Levinas where the Other is a primal relationship, prior to ontology. Such a view engages with the Other first, as a hostage to the call, and *then* considers resources. There is a potential problem within health care as part of the quasi market, and this is one regarding emphasis. With an economic *telos* and the use of personal employment objectives aligned to the Trust strategy, more emphasis could be placed upon the finite and necessary, rather than infinite and possibility. The consequent lack of synthesis results in the individual professional not being a Self–for-others. For sensitive ethical care an original awakening of an I responsible for the Other, is required.

The foregoing discussion has demonstrated the work of Kierkegaard, Levinas, and Sartre, as being suffused with a concern for the authentic individual. All three philosophers argue against a philosophy which reduces all things to a total synthesis of existence.

One of the main themes of this chapter was identified by Levinas at the outset; that ethics is prior to ontology. This proposal was considered during the discussion of some of the legal cases, where rationality involves a metaphysical reductionism that strives to eradicate difference, in order to secure knowledge.

In critiquing the legal case transcripts some of the positive contributions from the existential philosophers have been identified. For Kierkegaard, the individual is faced with a choice between the aesthetic which is a life of immediacy, or the task of

becoming a self in the ethical stage. Crucially for Kierkegaard, this existential movement involves freedom, from the potentiality of becoming a self, to actualisation. The aesthete explores countless possibilities, but does not choose any of them. A similar dynamic was encountered in Sartre, where he emphasised authenticity as social and other regarding. From this Sartre contributes to an understanding of the self as intersubjectively constituted. Some of the features identified from the cases discussed involved having a self-awareness in a social situation (clinical context), which involves developing a lucid awareness of all clinical interventions. Kierkegaard, Levinas and Sartre all emphasise the importance of the authentic self, with its freedom and responsibility, as contrasted with the totalised self which is 'existing merely in relation to others'. Levinas has highlighted the significance of this reductive rationalism not only at the level of the individual, but also at the organisational and political levels. Levinas insists that political totalitarianism is founded upon an ontological totalitarianism. That is, rationalism encourages individuals to think in an abstract way, which results in a detached approach to reality. The rationalised self is in an existential vacuum, distant from its surrounding reality. For Levinas, ontology reduces difference to sameness and in the process a rich pre-philosophical (ethics is prior to ontology) personal identity is lost.

The following chapter will analyse justice in 'Contemporary ethical problems in healthcare', before evaluating existentialism (Chapter Eight) as a potential way of ethical being in caring for patients.

CHAPTER SEVEN: CONTEMPORARY ETHICAL ISSUES: A SURVEY OF *APORIAI*

> Metaphysics, or the relation with the other, is accomplished as service and as hospitality. In the measure that the face of the Other relates us with the third party, the metaphysical relation of the I with the Other moves into the form of the We, aspires to a State, institutions, laws, which are the source of universality. But politics left to itself bears a tyranny within itself; it deforms the I and the other who have given rise to it, for it judges them according to universal rules, and thus as in absentia (Levinas 2008b:300).

Introduction

The previous two chapters have raised a number of generative questions. In considering the legal transcripts, discussion arose around how individual patients were cared for by the individual nurse, doctor or dentist. Some of the main arguments led into the political context in which health care staff work, and indeed where judges make legal rulings. In particular, the cases of Harry Coleman ([2004] EWHC 2931 (Admin), 2005] EWCA Civ 1172), and Naazish Khan ([2003] EWCA Civ 1129) point to a more radical analysis being required on the relationship between the citizen and the state, with particular attention being paid to concepts such as sovereignty, constitutionalism, and polycentricity. The legal process as explored previously will now be considered from the political perspective suggested by Allison:

> More fundamentally, however, adjudication should be viewed as a form of social ordering, as a way in which the relations of men to one another are governed and regulated (Allison 1994:357).

It is from this view of adjudication as a potential ‘form of social ordering’ that theories of polity, economy, and political economy will be considered in relation to the delivery of health care. The case of Ann Marie Rogers ([2006] EWHC 171 (Admin), [2006] EWCA Civ 392.) will be called upon again especially on considering political economy.

The aim therefore of this chapter is to continue with the threads of argument from the previous two chapters, but to now gather them into a small number of major themes around the relationship between the individual and the state. As previously done, the analysis will draw from Levinas, Sartre, and Kierkegaard. However, the discussion will now focus on the political level. On difficult points discussion between these philosophers will be brought out.

The overall approach taken in this chapter has been influenced by a number of philosophers. The structure was developed and influenced in reading a number of key philosophers. This provided a model framework to tackle such an analysis which considered the connection between philosophy and history, and philosophy and theology. MacIntyre’s Riddell Memorial Lectures (published as *Secularization and Moral Change)* were helpful in tracing the historical background to the process of secularization (MacIntyre 1967). Following this line of enquiry led to a more contemporary but complex perspective on the topic of secularization, which also includes the reverse process termed ‘sacralization’ where something secular, becomes sacred. This was uncovered by Charles Taylor in his book *A Secular Age* (Taylor 2007). This theme has been important as already discussed in conjunction with hermeneutics, but it also seems likely to be a perennial issue, even as it goes through many hues to

include other concepts such as multiculturalism. Due to this, this diachronic theme will be sustained in this chapter and appraised against some of the major challenges facing mainstream world religions - as influences in ethical decision making.

The legal theory will be discussed in relation to Kierkegaard's view of community and politics. Dooley expresses this where he argues:

> …the one abiding concern throughout is how to release the ethical from the sclerosis of dogma so as to keep it focused on what is essential and primary in all ethical considerations, that is, the single individual (Dooley 2001:xix).

In order to achieve the above aim, this chapter is an *aporia*-based inquiry, consisting of a survey of a small number of *aporiai* in health care ethics. The concept of *aporia* is founded upon the Greek language, with the prefix *a* meaning 'without', and *poros* denoting 'path or passage' (Mautner 1999:32). *Aporia* is variously translated as; no passage, an impasse, a puzzle or paradox, and as a lack of resources. The English words pore and porous share this common Greek root in the word *poros* (Soanes and Stevenson 2003).

Arriving at a state of *aporia* is part of a larger framework within ancient Greek conceptions of analysis, which were said to be of two kinds; one theoretical, and the other problematical (Geometry) (Woodruff 2010). Central to both of these methodologies is the regressive conception of analysis (Woodruff 2010). Of relevance

to the legal approach of cross-examination, and to the approach taken in this thesis, is the theoretical approach taken by Socrates, Plato, and Aristotle. In the early dialogues of Plato, Socrates demonstrates the elenctic method. Such an approach is derived from the Greek word *elenchein* which means to cross-examine, or refute (Vlastos 1982). Socrates used this approach in attempting to find a definition through dialogue with his interlocutors. Examples of such cross-examination can be found in *Charmides* (What is temperance?), *Laches* (What is courage?), *Euthyphro* (What is piety?), and in the *Meno* (What is virtue?).

The Socratic method, or method of elenchus is related to the concept of maieutics. This link is important in drawing out the various stages of elenchus, and also the different characterisations of *aporia* which will be discussed below.

The term maieutics derives from the Greek word *maieusthai* which will be recalled as meaning midwifery (Westfall 2009). As a midwife assisting the birth of ideas Sedley (2004) explains that there are three outcomes of Socrates' midwifery. These effects of midwifery appear to be linked to the different characterisations of *aporia*. The first outcome according to Sedley is where the individual is not pregnant and Socrates sends such on to other teachers who '…profess to supply information rather than extract it (2004; 35)'. In the next stage the individual is pregnant but they do not nurture their offspring (Sedley 2004). And the final outcome is where some '…give birth to many fine offspring (Sedley 2004; 36)'.

The term *aporia (ἀπορία)* has evolved in the writings of Aristotle and especially Plato, with a number of resultant functions which will now be briefly outlined in order to establish the meaning being used in this chapter.

In the early writing of Plato, the traditional use of *aporia* is where a search for a Socratic-type definition (What is F?) ultimately fails (Politis 2008a). In the *Meno* Socrates' induces a state of *aporia* in a slave boy precisely to demonstrate the *maieutic* role of the teacher, which is to test whether people really know what they think they know. This cathartic function of *aporia* cleanses the interlocutor[94] of any pretence at knowledge and assists them in identifying what they do not know. It signifies the end of a search to solve a problem and consequently renders the interlocutor speechless as they remain within a puzzled state. At an impasse. Such an *aporia* can be termed 'purgative' or '*cathartic'* (Politis 2008a). This is relevant to the cases of clinical negligence where reflexive knowledge contributes in helping individuals to identify the limits of their knowledge as part of ethical responsibility. In legal cross-examination it is used to try and establish the facts of the case. It is worth noting the various ways in which the characters in Plato's writings respond to being in a state of *aporia.* This ranges from *aporia* as something passive that happens to a helpless victim, through to it being a stimulus to search for an answer (Politis 2008a).

The aim and functions of *aporia* seem to be tied to the concept of movement as previously discussed in chapter 5, in that the individual must decide what to do in this

[94] Interlocutor is deliberately used here because this individual can only be called a learner if they take up the challenge and attempt to search fro a way out of the impasse.

situation of *aporia.* It will be recalled that Carlisle explained that 'Kinesis is, then, a category of transition, and it signifies a process of actualization (Carlisle 2005:12)'. This process is now considered in the other characterisations of *aporia.*

Significantly, the next characterisation of *aporia* is less well known. Politis explains where he states:

> The traditional view assumes that *aporia* in the early dialogues has only one aim and that Plato uses the term ἀπορία and its cognates in only the one way for just one kind of *aporia*. On this assumption it is natural that only the cathartic aim of *aporia* should stand out since it is indeed prominent and conspicuous. But this assumption is I think mistaken, and we will see that Plato, through the different characters in these dialogues, characterizes *aporia* in different ways. There are two very different characterizations, and rightly understood this means that Plato distinguishes two kinds of *aporia*: in addition to the cathartic *aporia,* there is a kind of *aporia* that is properly a part of searching *(zêtêsis)* –zetetic *aporia* (Politis 2008a:89).

This zetetic *aporia* can also be found in Aristotle. Aristotle outlines the usefulness of identifying and setting out *aporia* at the beginning of a philosophical argument. In the *Metaphysics* Aristotle proposes that:

> We must first enumerate the questions that should be first discussed (*aporêsai).* A preliminary discussion of problems is useful. A problem is like a bond which we cannot unloose until we understand its nature. A student who has not discussed the difficulties does not know the direction in which he should move, nor even whether he has found what he is looking for. The man who has heard the contending arguments is best able to judge between them (Aristotle .1924:221).

Plato provides a model of zetetic *aporia* in a number of his early dialogues. A *kinesis* can be witnessed in the individual who moves from being in a state of paralysis due to perplexity, to recognising the problem as a stimulus, to searching for an answer, and then in defining and discussing the problem. Crucially, the zetetic *aporia* does not indicate the end of an inquiry –as in cathartic *aporia*-rather, it is the beginning and starting point. In discussing reflexive knowledge in the *Charmides*, Plato provides a detailed example of a zetetic *aporia.* Some of the features of this dialogue are that Socrates '…will argue on both sides (*whether or not…)* of both parts of this question (whether or not it is, first *possible* and, second, *beneficial'* (Politis 2008b:7) to have reflexive knowledge. Further, such a zetetic *aporia* also recognises that there may be good reasons on both of the opposed sides of a question.

In a footnote Politis (2008b) explains that in a previous article (Politis 2008a) he considered the two characterisations of *aporia* as separate. Now he is of the opinion that they are closely related. In this chapter both the cathartic and the zetetic characterisations of *aporia* are being used.

The cathartic *aporia* is being used in the sense that the previous two chapters analysing the legal transcripts has led to an ethical impasse in that the law as posited is not followed, but rather Case law is regularly reinterpreted. From this perspective law and justice is always in the future. Current posited (codified) law is not followed, and therefore this practice is not legal-judges do not follow codified law.

The zetetic *aporia* is being used to define an extended inquiry into a problem with reasonable arguments on both sides of the opposed sides of the question. The main question is *whether or not* the current political structure supports the ethical care of patients. Since it is an open question definitions of legal justice will be used to evaluate the dialogue on both sides of the question regarding *whether or not* it is beneficial to patients (claimants).

This chapter is looking for a way in which the individual is free to act, free from external binding influences. The philosophical term *aporia* has been used in recognising the complexity and difficulty of the path. From a position of doubt the analysis plans to consider arguments from a number of perspectives (paths) in order to demonstrate they are in fact ethical impasses. This then leaves the way clear for a consideration of Kierkegaard's political philosophy. The discussion and argument within this chapter has been divided into the following sections;

Locating Ultimate Authority in Justice.

Aporia 1. Sovereignty and the nation-state.

Aporia 2. Sovereignty at the supranational level.

Aporia 3. Constituent and Constituted power.

Aporia 4. Citizenship.

Aporia 5. Secularisation as an Influence upon Ethical Decision Making.

Kierkegaard's view of Civil Society.

Conclusion.

Locating Ultimate Authority in Justice.

There were two striking statements made in chapter 6 which have highlighted an important area for further investigation. The first was in the Wednesbury case (Associated Provincial Picture Houses, Limited v Wednesbury Corporation. [1948] 1 K.B. 223.), where Lord Greene ruled:

> In such a case, again, I think the court can interfere. The power of the court to interfere in each case is not as an appellate authority to override a decision of the local authority, but as a judicial authority which is concerned, and concerned only, to see whether the local authority have contravened the law by acting in excess of the powers which Parliament has confided in them ([1948] 1 K.B. 223: Line 234).

The second statement was from Mr Burnett QC where he warned; 'The court should not be seduced into achieving by judicial activism a change that is properly a matter for legislation. ([2004] EWHC 2931 (Admin): paragraph 36)'.

Both of these statements seem to be important in the case involving Harry Coleman ([2004] EWHC 2931 (Admin), 2005] EWCA Civ 1172), but they also appear to lead to some fundamental questions about justice, and in turn the consequences for ethical behaviour. In the previous chapter it was established that when Mr Coleman's' daughter presented with some questions about her father's clinical care, the legal system responded with some surprising legal manoeuvres. Some of the key points to be recalled are that; the coroner decided that article 2 of the ECHR was not engaged due to the NHS Trust not being a State body. This was later revoked; The Coroner was

presented before the court in a protected status, and was as such not open to questioning on his decision making; The Coroner made his judgement of finding no clinical negligence based upon *Wednebury;* And finally, Mr Burnett QC presented a cost argument for why the coroner did not use an independent expert, and also as a warning to the court if they should rule in favour of the claimant. It is these facts which are now going to be explored in some detail.

Rawls (1999) states that justice as fairness begins with the choice of the first principles of a conception of justice. The work of Rawls is helpful in providing one conceptual framework, from which discussion can take place in a systematic manner. Being a hypothetical framework it provides a contrast to Existential philosophy. Rawls model of fair choice involves two important aspects. These are that the individual must place themselves in the *original position*, which entails the *veil of ignorance*. Rawls proposes that by placing ourselves into this thought experiment we will be able to establish the rights and duties of justice that we owe to the other.

Firstly the structure of the political status quo will be outlined before considering this in relation to Kierkegaard's view of genuine community life. In the process some of the tensions envisioned by Kierkegaard will be considered, especially where he thought;

> The longer life goes on and the longer the existing person through his action is woven into existence, the more difficult it is to separate the ethical from the external, and the easier it seems to corroborate the metaphysical tenet that the outer is the inner, the inner the outer, the one wholly commensurate with the other. Exactly this is the temptation, and for this reason the ethical becomes day by day

> more difficult, consisting as it does in that true hypertension of the infinite which is the beginning, and where it is therefore most clearly apparent (Kierkegaard 1992a:138).

Viewing the status quo will first be considered through the concept of sovereignty.

Aporia 1. Sovereignty and the Nation-State

The analysis in the previous two chapters leads to the question of why the judges made the decisions they did. When all of the legal process is followed, the *ratio* of the Case cross-referenced, and the final legal opinions considered, it seems that the judicial process exhibits a high degree of indeterminacy. Some of the cases raised the question of the power of the court to interfere, or indeed the limits placed upon judicial power, due to, for example, such mechanisms as the 'separation of powers', devolution legislation, and European law.

How power is viewed has consequences for any theory of being (ontology), normative theory, and in turn the way patients are cared for. Sovereignty is the modern concept which originally expressed the idea that there must be a final and absolute authority in the political community (Hinsley 1966). The idea of sovereignty leads to perhaps *the* most fundamental debate within the philosophy of law which concerns the extent to which law should be kept separate from morals. The two main opposing schools of thought (Natural Law and Legal positivism) have had a long historical debate which continues today. The most succinct description of natural law is provided by D'Entrèves where he explains '…that it provides a name for the point of intersection between law and morals (D'Entrèves 1994:116)'. In contrast, legal positivists believe

there is no necessary connection between law and morals, laws are commands of human beings, and that a legal system is a closed logical system (Hart 1997). The term 'positivism' comes from the Latin *positum*, which describes the law as it is laid down or posited (Wacks 2006).

That the concept of sovereignty has a fluid meaning is undisputed. As a concept it is ill defined (Walker 2003, Ilgen 2003). The traditional view of sovereignty is that based upon the Westphalian model (Berg & Kuusk 2010). In this model sovereignty is the very relational interface between law and politics and:

> 'comes into existence through a process in which a group of people within a defined territory is moulded into an orderly cohesion through the establishment of a governing authority that can be differentiated from society and which is able to exercise an absolute political power (Loughlin 2003:56).

Unlike Levinas's view of responsibility to the other, sovereignty is a concept defining limits to responsibility through boundaries. It is recognised that political power is not the sole influence upon social behaviour. Hinsley (1966:3) explains this where he states:

> At no time, in no society, has the political system been the only agency or institution in the community. In the most advanced societies, as in the most primitive, the law it lays down is never the sole code regulating social behaviour, and the role of citizen is but one of several roles which each man plays as a member of society.

This is partly why secularisation will also be explored later. However, in the meantime, the limiting effect on political power in the concept of sovereignty will be uncovered.

Defining the territory to be ruled has been a significant historical aspect within sovereignty. Given the fact that sovereignty in its modern definition has developed from the theological concept (Schmitt 1985, Buijs 2003), it is useful for the purpose of analysis to recognise the tensions within the framework between absolute sovereignty as conferred upon a deity, and that which is more of a geographical nature.

Significantly, limits to resources is also implicit within the definition which is not surprising in an economic calculation of responsibility, but the subtlety of limiting the potential for thinking what could be done, may well go unnoticed. For Levinas the responsibility is prior to the economic calculations, which would follow later. Regarding such risk calculations Kierkegaard proposed;

> But the ethical never raises questions of worldly wisdom; it merely demands understanding enough to discover the danger-in order then to go boldly into it, which indeed seems very stupid. Oh, strange power that is in the ethical! (Kierkegaard 2009b:117).

Later in the same paragraph Kierkegaard proposes the approach to be taken; ‘and the trick simply to be enthusiastic, as another author has said: to be joyful out on the 70,000 fathoms deep’ (Kierkegaard 2009b:117).

Physically, the state is the political institution in which sovereignty is embodied. Within western constitutionalism sovereignty is categorised into three areas of public power through the concept of 'separation of powers' (Morrow 2005). The separation of legislative, executive and judicial functions proposes a system of checks and balances of power. In reviewing the separation of powers within the Commonwealth constitutional tradition Saunders (2006:4) finds:

> By contrast, the constitutional arrangements in the United Kingdom are quite different, in key respects. Unlike the United States, this country has a parliamentary system with at best a weak institutional separation of the legislative and executive branches.

The purpose of tracing and uncovering the concept of sovereignty here is to establish where ultimate political power lies, prior to considering what actually happened in the selected cases of alleged clinical negligence. For the rationale of constructing a philosophical argument the key milestones will be set out, where the high detail is to be found in the work by Walker (2003) and Bogdanor (2009).

To bring together the key features above on British constitutionalism, it can be established that this consists of the sovereignty of Parliament. The relevant path of power is expressed through 'unitary legal authority premised upon centralised political authority expressed through the will of Parliament (Armstrong 2003:328)'. Armstrong (2003) outlines some relevant consequences from the above to the current discussion on the validity, priority and continuity of parliamentary sovereignty. This adds to the previous discussion on the doctrine of legal precedent in chapters 2.2, and 5. Now it

can be seen that the sovereignty of Parliament is above legal precedent and Case law because; laws enacted by Parliament are legally valid; the courts have a duty to apply the latest will of Parliament above other law which includes Case law; and finally, sovereignty cannot be legally limited (Armstrong 2003). Here, at source, is the ultimate legal principle-Parliamentary legal power could not detract from its own continuing sovereignty (Craig 2000). Ultimately, '…the source of its authority being historical rather than legal (Craig 2000:223)'. While viewing the source of legal authority and Parliamentary omnipotence it is worth identifying some final relevant points. That is, that Parliament cannot come under legally binding rules that would limit its legislative powers. Equally evident is the way the particular political theory by the ensconced government of the day is enshrined in the legislation adopted by Parliament. And the final point will be discussed later in relation to Kierkegaard's view of community which considers the sovereignty of the polity. This seems a moot point as Craig explains:

> The constitutional discourse of previous generations reveals an awareness of the need for principled justifications for the existence of sovereign power, in a way which has been largely forgotten (Craig 2000:224).

Before focussing the discussion down to the level of the individual, and considering Kierkegaard's perspective on community, some of the wider challenges within the legal and political systems will be considered.

***Aporia* 2. Sovereignty at the Supranational Level**

The legal cases of Harry Coleman ([2004] EWHC 2931 (Admin), 2005) EWCA Civ 1172), and Naazish Khan ([2003] EWCA Civ 1129) drew upon the statute law within the Human Rights Act. Central to both cases was the belief –as expressed in the Human Rights Act-to a fair legal trial. It is however now worthwhile re-examining the legal process under the concept of sovereignty. Clearly in both cases there was clinical negligence. In Mr Coleman's case, the consultant surgeon had accidentally perforated his bowel during the laparoscopic procedure. Whilst this was the source of the problem, the more concerning issue was the nurses and doctors lack of clinical intervention. In fact the nurse diligently documented the deterioration of Mr Coleman as if it were in a novel (Kierkegaard's aesthetic stage), rather than in the real ethical or religious spheres. For Kierkegaard the different spheres are to assist the individual to see where they are in their own ethical development. Some of the relevant features are that there is a movement, from a less to a more truthful form of life, becoming increasingly inward and increasingly passionate. Kierkegaard also explains the spheres of existence as distinguishing between two ways of relating to the world. That is through knowledge (aesthetic) and through a subjective passionate concern with meaning in life. The problem of regarding the truth solely in terms of knowledge, is that it identifies a valueless and meaningless world.

Just as prominent is the clinical negligence in the case of Naazish Khan where the nurse administered a fatal overdose of potassium to the three year old girl. At the clinical level any registered health care professional would readily identify the behaviour in the cases above as clinical negligence. To make it more objective, if this

care was measured against clinical protocols developed from text books; it would deviate significantly from the expected minimal norm. Yet in law these cases are classed as ‘hard’ cases.

In contrast to ‘clear’ cases, ‘hard’ cases are where established rules or laws are unable to provide conclusive answers, and therefore cause indeterminacy in law (Bunnin and Yu 2004). It is at this juncture where a number of considerable philosophical issues arise which together bind towards the main argument at this stage. Each will be considered in turn before reintegrating them into the overall whole.

The ‘hard’ cases – which according to Freeman (2001:1392) are ‘nearly all cases that reach the stage of argument in court’ - uncover the extent to which the judges have *discretion*. Hart outlines this open texture of law where he writes;

> In every legal system a large and important field is left open for the exercise of discretion by courts and other officials in rendering initially *vague* standards determinate, in resolving the uncertainties of statutes, or in developing and qualifying rules only broadly communicated by authoritative precedents (Hart 1997:136), Emphasis added.

Yet in previous chapters it was established that due to the technological advances within healthcare precisely how challenging this was for both jurists and juries. In the cases being discussed, laparoscopic surgery, and the use of renal dialysis as part of chemotherapy are relevant examples. Previously the work of Dwyer (2007, 2008) also

identified both the dependency and therefore the vulnerability of judges when requesting Expert Witnesses.

Where this bears relevance within the philosophy of law is in the historical movement away from natural law, towards law as posited (legal positivism). Freeman (2001:199) provides a helpful overview of this development where:

> The new approach was essentially secular and positivist, and though lip-service continued to be paid to a notional subjection to overriding natural law, the supporters of legal sovereignty tended increasingly to whittle down natural law from a system of norms to a mere statement of human impulses explaining the need for a sovereign power in human society, as with Hobbes, or to a mere formal category to justify a belief in inalienable sovereignty, as in Rousseau's theory of the general will. But as became apparent in the writings of Hume, true empiricism really involved the rejection of natural law as a system of norms, as Hume argued, the validity of normative rules cannot logically be treated as an objective fact, but depends on the relative viewpoint of those who apply them.

The present argument is concerned with uncovering where ultimate authority lies within the polity and has been using the concept of sovereignty to structure this enquiry. Before continuing this line of exploration into the influence of European law, it is worth identifying a linkage at this stage, of parallel change within law and theology. This is where, through the process of secularisation, theology has also undergone a transversion towards being more homocentric.[95] While this will be discussed at a later

[95] Transversion is a term used within genetics to refer to the changes within the structure of DNA and its ongoing consequences to the health of the system (human). A 'Transition' is a straight exchange with a

point in more detail, binding the two together here identifies the hermeneutical challenges within law and theology from this revised homocentric stance. This foundational change has thrown up a wide range of 'ethical' debate within theology regarding reinterpretation of canonical text from this new horizon. Although there is a long list of topics, the following provides a short synopsis of some of the current debates; abuse of children and vulnerable young people (Pope Benedict XV1. 2010); that in Messianic Judaism believers must fully observe the Mosaic Law (Law of Moses) (Smith 2010); same sex relationships, and also the ordination and induction of ministers who are in same sex relationships (The Church of Scotland 2007, 2009);and the final example; whether there should be women bishops in the Church of England (The Archbishops Council (2004). The significance to the current argument is that theology when popularised loses both its theoretical structure and authority. Robertson (2010) captures the consequence of this where he explains that as traditional institutions of moral authority have lost power, constitutional judges have stepped into the breach, and radically altered traditional views of what courts can and should do. The relevance of Kierkegaard in reviewing these changes within theology can be seen where he outlined the consequences of popularism:

> In our age the principle of association (which at best can have validity with respect to material interest) is not affirmative but negative; it is an evasion, a dissipation, an illusion, whose dialectic is as follows: as it strengthens individuals, it vitiates them; it strengthens by numbers, by sticking together, but from the ethical point of view this is a weakening. Not until the single individual has established an ethical stance despite the whole world, not until then can there be any question of

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similar protein, whereas a 'Transversion', while less common, is an exchange on a different level and has ongoing significant changes to the system as the DNA continues to knit the new pattern.

> genuinely uniting; otherwise it gets to be a union of people who separately are weak, a union as unbeautiful and depraved as a child-marriage (Kierkegaard 2009c:106).

With the link to theology established, the argument can now continue to explore how association with Europe through the Human Rights Act (European Convention on Human Rights), potentially vitiates individuals. The aim of this section in the discussion is to uncover some of the outcomes in moving away from the traditional Diceyan model of sovereignty, to a rights based system. Such dialectic will uncover through cross-examination that at the heart of a rights based system lies a metaphysic of the self, as a theoretical construct of an unembodied being. It will continue with Kant and Sartre's perspective - as previously outlined - where people are a 'means to an end', rather than as 'ends in themselves', where their roles and ends are defined by the political system. Sartre confirms this when he said;

> There are indeed many precautions to imprison a man in what he is, as if we lived in perpetual fear that he might escape from it, that he might break away and suddenly elude his condition (Sartre 2000:59).

This perspective from Kant and Sartre will be set off-stage (waiting in the wings) while the rights based system is weighed up against Kierkegaard's view of civil society. The issues raised in the Harry Coleman and Naazish Khan cases will continue to inform the exploration. For Mr Coleman his family wanted to engage article 2 of the ECHR to thoroughly investigate his death in hospital. The Khan family wanted the death of Naazish investigated under the same European legislation. At the first court hearing the presiding judge in the Khan case, The Honourable Mr Justice Silber concluded;

> In common with everybody who has heard about the tragic death of Naazish, I have the greatest sympathy for the claimant and his family but my task is to apply the law which I have sought to do…Third, in any event as Naazish died before the 1998 Act came into force, the state did not have any adjectival duties under Article 2 ([2003] EWHC 1414 (Admin) paragraph 99).

It is this delimitation of responsibility which will continue to be reviewed through the association with European jurisprudence. To be detailed in the timing of events, Naazish Khan died on the 8th of October 1998, with the HRA 1998 being given Royal Assent on 9th of November 1998, and it came into force on the 2nd of October 2000. This raises questions about which concept of justice is being rendered in this case. Zook captures some of this essence in Kierkegaard's work where he comments:

> Kierkegaard's opposition to closed, institutionalized frameworks of civic interaction stems from their tendency to relieve civic actors of their ethical burdens and responsibilities, thereby weakening the bonds that hold civil society (Zook 2008:399).

First, a brief outline of the Human Rights Act will be given, before considering the political and economic consequences.

One of the key features of sovereignty is in defining the boundary within which to have authority and to rule. Commonly the theoretical construct includes both Internal and External elements. The doctrine of *rex est imperator in regno suo*[96] remains helpful in

[96] The king is emperor in his own realm.

identifying where ultimate authority lies, and from this what laws and values are important within this kingdom.

Adoption of The European Convention on Human Rights and Fundamental Freedoms (ECHR) through the Human Rights Act 1998 in October 2000, set in motion a revision to existing ideas of traditional Dicean sovereignty within the United Kingdom. The theoretical change underpinning the legal system was prescient in the Tom Sargent Lecture in 1997 where Lord Irvine said:

> As we move away from the traditional Diceyan model of the common law to a rights based system, the effects will be felt throughout the common law and in the very process of our judicial decision making (Lord Irvine 1997:9 &10).

Importantly, this change would affect all law, including the Tort law of negligence (Arden 2010). At this stage it is worth recalling the historical aim imbedded within the HRA, and ECHR as being tied back to the post-war Universal Declaration of Human Rights (UDHR 1948) (Arden 2010). The broad ethical values contained within all three documents are aimed at establishing fair and tolerant societies (HRA 1998, ECHR 1950, UDHR 1948). Contained within these statutes is a search for the balance between the rights of the individual and the wider rights of society (Millet 2005: paragraph 11).[97] Consequently, at the theoretical level a search for the equilibrium between freedom and constraint.

[97] Klug (2007:4) states that 'The exception to this search for 'balance' are the rights to be free from torture and slavery which are neither qualified nor limited under the ECHR'.

In considering the source of ultimate authority within the polity the following influences will be considered; The European Court of Justice (ECJ) in Luxembourg as the Court of last resort; When British courts are considering a Convention right, they are required to take into account the jurisprudence from the European Court of Human Rights (EctHR) in Strasbourg, France (Arden 2010); The European Union (EU) is an economic and political union which has a single economic market. As the largest economy in the world, consideration will now be given to the integration of these factors on the concept of justice. Where justice was previously considered at the Domestic level in chapter 5 (section 2), analysis will be carried out at the European level of law. Once again Deakins proposition will be explored;

> Thus, the politicization of tort law is thus becoming obvious in our system as well as the patchy nature of our reforms clearly reflect either the impact that pressure groups have on the generation of 'partial' legislation or even the introduction of legislation which openly admits as its first objective the desire to save the NHS money (even if the long term effects of this reform remain openly uncertain) (Deakin et al. 2008: 8).

One final aspect for consideration will be brought in at this point, with one final contribution of additional theory. Deakin et al. (2008: 8) proposition above alludes to the influence of pressure groups upon legislation, and the setting of boundaries. In the legal transcripts reviewed, the case of Ann Marie Rogers is a paradigm example (Chapter 6.2). It will be recalled that in this case, the Health Secretary (Patricia Hewitt) bypassed the decisions of NHS regulators and NICE and informed NHS Trusts that they could not refuse to fund Herceptin on grounds of cost alone. This seemed to be a

case which challenged the concept of sovereignty and the boundaries of law, through the collective power of the people played out in the national press. At this juncture the theoretical construct of Carl Schmitt regarding Sovereignty is helpful in clarifying boundaries within politics and theology.

Schmitt commences his definition of sovereignty with the opening declaration: 'Sovereign is he who decides on the exception (Schmitt 1985: 5)'. This idea has similarities in the work of Taylor – to be discussed later - where consideration is given to secularisation as a move from an *enchanted,* 'porous' state of being, to a 'buffered' state which admits no exceptions. Taylor summarises the state where he explains:

> As a bounded self I can see the boundary as a buffer, such that the things beyond don't need to "get to me", to use the contemporary expression. That's the sense to my use of the term "buffered" here. This self can see itself as invulnerable, as a master of the meanings of things for it (Taylor 2007:38).

Within healthcare, the Evidence Based Practice (EBP) ideology has greatly contributed to this construct of the 'buffered' self, and also a scientific research process which eradicates exceptions. Relevant to the current discussion is the end point of such a belief system (EBP), where there is considered to be no such thing as an accident within clinical practice. A supportive example would be where Davis and Pless (2001) wrote in the British Medical Journal explaining that the journal had decided to ban the word accident from its pages. This was premised upon the claim that 'most injuries and their precipitating events are predictable and preventable (Davis and Pless (2001:1320)'. This was one of the striking features of the news when Hewitt bypassed The National

Institute for Health and Clinical Excellence, in performing their role of appraising evidence for clinical practice.

For Schmitt the exception is a useful tool to undercover fundamental questions about sovereignty. In cases such as the Herceptin example, Schmitt analyses the situation as 'Although he stands outside the normally valid legal system, he nevertheless belongs to it, for it is he who must decide whether the constitution needs to be suspended in its entirety (Schmitt 2005:7)'. In the Herceptin situation the support gathering to individuals suffering from breast cancer which would be suitable for treatment with Herceptin, threatened to undermine the authority of the government. Schmitt explains:

> From a practical or a theoretical perspective, it really does not matter whether an abstract scheme advanced to define sovereignty (namely, that sovereignty is the highest power, not a derived power) is acceptable. About an abstract concept there will in general be no argument, least of all in the history of sovereignty. What is argued about is the concrete application, and that means who decides in a situation of conflict what constitutes the public interest or interest of the state, public safety and order, *le salut public*, and so on. The exception, which is not codified in the existing legal order, can at best be characterized as a case of extreme peril, a danger to the existence of the state, or the like. But it cannot be circumscribed factually and made to conform to a preformed law (Schmitt 2005:6).

Previously, ontology has been thought about at the individual level in relation to ethics. In this next section ontology is going to be applied to the institutional level of the European Union. Schmitt's incisive analysis will be followed by the concrete application of the concept of sovereignty to the discussion. It will continue to focus on the notion of justice within the human rights framework. As in the foregoing chapters,

the analysis will proceed from the micro to the macro, at this level the individual professional will be substituted for discussion at the state level, with the same structure followed in thinking about the dynamics of a member state within the European Union in relation to authentic being.

Within Europe[98], the European Union has made a claim to ultimate authority in relation to the member states through the doctrine of supremacy of European law. This was set out by the ECJ in some seminal decisions such as that expressed in the Costa case:

> By creating a Community of unlimited duration, having its own institutions, its own personality, its own legal capacity and capacity of representation on the international plane and, more particularly, real powers stemming from a limitation of sovereignty or a transfer of powers from the states to the Community, the Member States have limited their sovereign rights and have thus created a body of law which binds both their nationals and themselves (Flaminio Costa v E.N.E.L. [1964] ECR 1141:3).

From the above ruling it can be seen that that there is a direct link between the ECJ as a political unit, and individual citizens, where previously this was exclusively with their own nation-sates (Olsen 2008). In relation to a theory which influences the behaviour of citizens and in setting out norms this is an influential development. This is made explicit in the following statement in Costa:

[98] The current discussion is focussed upon Europe. One the structure is set out, the discussion will consider a global view.

> The transfer by the states from their domestic legal system to the Community legal system of the rights and obligations arising under the Treaty carries with it a permanent limitation of their sovereign rights (Flaminio Costa v E.N.E.L. [1964] ECR 1141:3).

Such a transfer of legal rights would affect the individual citizen within both a legal (ECJ) and economic framework (European Economic Community (EEC)). This new milieu would cut across the borders of previously insulated legal-political systems in terms of membership and rights (Olsen 2008). These changes would not just affect the individual on the horizontal dimension across national boundaries (transnational), but also on the vertical plane through the creation of a hierarchical, direct link with the European community (supranational). Dual membership then as a citizen of the nation-state and European community constitutes the individual citizens identity, provides the notion of inclusion and exclusion criteria of membership, and importantly, contributes to the definition of *other*.

Further, as a citizen within the EEC, the economic framework involving a common market was, -and continues to- contribute to the identity of an individual as worker. Oliver captures some of these changes:

> These developments in the practical and political conditions in which parliamentary sovereignty is exercised in the UK represent radical departures from earlier practice. They affect our understanding of Parliament's position in the Constitution. It is no longer at the apex of a simple hierarchy of strictly legal norms. Instead a more subtle and varied network of relationships between laws or rules of different kinds and from different sources is developing. At the highest, Parliament is at the centre of a web rather than at the apex of a pyramid (Oliver 2003:357).

From these changes the question arises of who authorises the European community to take such freedom to act. Under the previous Westphalia system, this could be viewed as a threat to external sovereignty. This question will be considered in the next section on how the constitution is instituted.

Aporia 3. Constituent and Constituted Power

In continuing to consider the ultimate authority of the European Convention on Human Rights as applied in the Khan and Goodson cases, the European Community is a useful exploratory model on a number of levels. The discussion will continue to unravel the legal structure down to the level of the individual citizen in the hope of discovering the main influences upon a normative theory. What appears to be new will be referenced to what appears to be prescient in Kierkegaard's work. For Kierkegaard foresaw:

> System and conclusiveness correspond to each other, but existence is the very opposite. Abstractly viewed, system and existence cannot be thought conjointly, because in order to think existence, systematic thought must think it as annulled and consequently not as existing. Existence is the spacing that holds apart; the systematic is the conclusiveness that combines (Kierkegaard 1992a:118).

Regarding authentic existence, sovereign constituent power is a founding power, creating force, and as such defines boundaries. The boundaries define the identity of those given membership and those declined as *other*.

It has been established above that the European constitution preceded the European constituting power, in that the legal framework was drawn up prior to a European

people being in place. The European constitution was developed upon the national-state constituting power. Such an approach raises problems regarding the legitimacy of this framework. Lindahl (2007a) explains the opposing views of constituting power, where Carl Schmitt gives primacy of place to constituent power over constitutional power and democracy over the rule of law. Whereas, Hans Kelson by contrast, proposes that the people in a democracy has no prior political existence until it is recognised by legal rule. According to Lindahls' (2007a) analysis, in Schmitt's eyes, Kelsen collapses constituent into constituted power, and politics into law, by denying the prior existence of the people as a political unity. However, Kelsen's legal framework recognises a paradox at the heart of the law (Lindahl 2007b). If the logic of the *Costa* ruling (above) is taken as an example in creating the European community, it can be established that there was no norm of pre-existing positive law. The problem then arising for Kelsen is recognising this power that creates the first constitution without being *legally* empowered to do so. The constituent sovereign appears external and prior to any established system of positive laws (Kalyvas 2005).

Constituting power is ambivalent in its relation to the constituted power. The constituting power, while founding the constitutional order remains irreducible to and heterogeneous from that order. The importance, according to Kierkegaard of each single individual basing their actions upon a higher ethical criterion will be discussed in the next section. For how individuals view their freedom will influence both as a constituting power, and the constitution. As individuals group together to make a polity, this very act demonstrates the inextricable relation between autonomy and heteronomy.

Kierkegaard warned of the danger of the state's self deification, and a legal system that had no external criterion upon which to judge itself.

At the domestic, nation-state level, sovereignty can be seen to operate, with a geographical area defined, a people to protect (and as part of a covenant the same give up self- rule) and rule, and also the freedom to define the Common good. The advent of the supra-nation has however given birth to a complex system with boundaries which define members and *others.* It appears notable here that the citizens give-up a degree of self-rule both at the domestic and supra-national level in return for 'protection' it its broadest definition.

Tied to the notion of sovereignty within the European Union was the development of the Common market. For the past thirty years the governing philosophy of the United States of America and the United Kingdom has involved the belief that Markets are the vehicle to achieve the public good (Sandel 2009a). For any normative theory, it can then be seen that both the legal and economic frameworks are aligned towards market-orientated ways of conceiving citizenship. Importantly, this includes calculations of economic cost in determining justice within claims of clinical negligence. However, the self-interest identified by Adam Smith (1904) as a dynamic to a competitive market can create problems in deciding how to value the goods. This seems to be relevant when in healthcare, caring is the commodity.

Sovereignty at the domestic level was a hostile and competitive structure, rather similar to Smiths view of self-interest, only transposed to the national level. Such a view is

continually challenged by globalisation. Korten et al. (2002) provide a useful comparative analysis of the two opposing world views of empire and community. In the worldview of empire the only positions life offers is to rule or be ruled, to be a winner or a loser. Whereas the world view of community allows for creativity, and the equitable sharing of power and control of resources. In discussing the role of market economies Sandel proposes that careful consideration should be given to when to use markets as some things are corrupted or degraded when turned into commodities. Regarding this question Sandel explains;

> To decide them democratically, we have to debate case by case the moral meaning of these goods in the proper way of valuing. This is the debate we didn't have during the age of market triumphalism. As a result, without quite realising it, without ever deciding to do so, we drifted from having a market economy to being a market society. The hope for moral and civic renewal depends on having that debate now. It is not a debate that is likely to produce quick or easy agreement. To argue about the right way of valuing goods is to bring moral and even spiritual questions into public discourse (Sandel 2009b:9).

The dynamics of a market society further define alterity. Given that there has been a move away from sovereignty towards universal human rights, this section will consider such rights in light of a market economy.

At the domestic level there is a perception by the public that too many asylum seekers and immigrants take advantage of the Human Rights Act. In one poll conducted for the Ministry of Justice, 43 per cent of the public took this view (Ministry of Justice 2008). The same research found that - in keeping with Sandel's view - the general public

perceive a general lack of respect, what they termed a 'values vacuum' (Ministry of Justice 2008). Sandel (Sandel 2009b) believes there is now a widespread sense that markets have become detached from fundamental values. In continuing with the question of legitimacy of the European community, when Lady Justice Arden reviewed the ECHR with regard to tort law she concluded;

> The result is that there is a great deal of discretion in the hands of the judges to decide whether or not the common law will be developed in accordance with Convention rights…(Arden 2010:149).

Correspondingly, Shah and Poole (2009) found when evaluating the impact of the HRA on the House of Lords that the court is busier, but there is a low win rate for human rights cases. Post-HRA, 42 pre cent of the courts caseload is composed of human rights related cases. This compares with 17 per cent pre-HRA (Shah and Poole 2009). As a system endorsing universal human rights, Shah and Poole interpret the statistics thus; 'A more likely explanation is that while the Lords may be keen on hearing human rights cases, they are not particularly sympathetic in general to human rights *claims*[99](Shah and Poole 2009:13)'.

If the route is followed in trying to raise issues with universal human rights-as in the clinical cases under consideration-further stumbling blocks (*skandalon*) will be discovered in attempting to make a claim. In completing the discussion at the domestic level, the final point to make is that it is only unlawful for public authorities to act in

[99] Italics in the original.

conflict with human rights. It does not operate at the private or individual level (Arden 2010).

At the supra-national level forty-seven European states currently make up the Council of Europe, which participates in the European Court of Human Rights in Strasbourg. As has been discussed above, claimants must first exhaust the domestic legal system before presenting a claim at Strasbourg. Some of these cases from some countries can involve extreme human rights abuses (The Guardian 2009). Yet the court is at risk of becoming hamstrung due to the sheer volume of claims presented, and the resultant backlog of cases. This has been a sustained problem, as in 1999 the court had a backlog of 60,000 cases (Verkai 1999). At the beginning of 2010 the court had a backlog of over 120,00 cases and a multi-year waiting list (European Court of Human Rights 2010a).In August, this is now 138,200(European Court of Human Rights 2010b). This is even with revision to the structure of the court (Ochsenbein 2010). It is worth noting that Russia currently has the largest number of pending applications making up 27.6% of the total claims (European Court of Human Rights 2010b).

Attempts to annul existence in all or any of it forms (ethical, legal, economic, political) by the system (national or supra-national) provides space for re-activation of the constituent power which according to Derrida lies in a dormant and subterranean form. ‘Existence is the spacing that holds apart (Kierkegaard 1992a:118)’ according to Kierkegaard. Such a dynamic exposes the vulnerability and therefore the instability of the constituted power.

Andrei Sakharov who won the Nobel Peace Prize for – amongst other major contributions - exposing how laws can contribute to hatred wrote in his autobiography;

> For me, the moral difficulties lie in the continual pressure brought to bear on my friends and immediate family, pressure which is not directed against me personally but which at the same time is all around me. I have written about this on many occasions but, sad to report, all that I said before applies equally today. I am no professional politician - which is perhaps why I am continually obsessed by the question as to the purpose served by the work done by my friends and myself, as well as its final result. I tend to believe that only moral criteria, coupled with mental objectivity, can serve as a sort of compass in the cross-currents of these complex problems (Sakharov 1975).

After considering the problem for many years Sakharov identified moral criteria and mental objectivity as potential guides. However, some of the concerns he wrote about remain contemporary. In writing about the economic crisis in Europe Thornbjørn highlighted some of the tensions in living in the nation-state, and supra-nation state simultaneously;

> To participate fully in multicultural societies we need a well-developed sense of identity, but growing unemployment and marginalisation mean people lose that identity and start defining themselves in opposition to others – fertile ground for extremists to spread their message of hatred (Thornbjørn 2010).

So far the discussion has attempted to outline many of the boundaries required by sovereignty from the domestic level up to the supra-nation state of the community. The

structure however, continues to define alterity at the supra-national state level. That is for example those who are out with the European community as other. Two final examples will be discussed in this section before considering how the institutional structure influences the individuals' identity as a citizen. The following two examples aim to uncover some of the consequences upon a normative theory when the system so far discussed is rolled out to the global picture.

In defining alterity the supra-nation state develops a necessary boundary against third world countries. Necessary, in terms of an economic system which requires self-interest as a force to drive the free market. Turner (2004:175) goes further and suggests that the 'global economic system depends on the continued existence of these impoverished societies'. Researchers, bioethicists, and healthcare professionals are socialised and embedded within the boundaries (immanence) of their domestic, and at most supra-nation state level. The research agenda and scholarship (including ethics) is funded towards the common good for that nation. Here there is the potential skewing of the research agenda as savvy researchers develop research applications where there are grants to be found. In contrast, Rennie and Mupenda (2008) discovered global health disparities when they carried out their research on ethical issues in biomedicine and public health research in the democratic republic of Congo. In all of the epidemiology studies presented by Rennie and Mupenda (2008) there is a stark contrast between the richest and poorest countries. Perhaps the most striking is that regarding the maternal mortality rate. The lifetime risk of pregnancy-related death in Malawi is 1in 7, as compared with 1 in 2800 in industrialized nations (Meguid et al. 2007). It is then from this contrasting perspective that Turner (2004) proposes that the long list of

contemporary bioethical issues (face transplant, stem cell research) are only intelligible in the socialisation of wealthy developed nations. Current issues in bioethics are more focussed on issues of personal autonomy, than social justice at the global level (Farmer 2004). Socialisation at the nation-state level is similar to living in Kierkegaard's Aesthetic sphere as previously discussed, which is a life of immediacy. Regarding the Maternal Mortality Ratio (MMR) in Malawi, and the political thinking of sovereignty in particular, Kierkegaard explains;

> But to exist signifies first and foremost to be a particular individual, and this is why thinking must disregard existence, because the particular cannot be thought, but only the universal (Kierkegaard 1992a:326).

The particular is prior to the constituted power as a dormant and subterranean power. Within the supra-national state framework the current world-view as Empire requires states to compete with each other for global economic power. Focus currently is upon the BRICs, which in economics is the acronym referring to the countries of Brazil, Russia, India, and China. In defining the common good, China decided to move from a socialist planned economy in the 1980s to a market economy (Keping 2009). Economically China's strategy has been a success. A précis of the statistics show that China's Gross Domestic Product (GDP) increased from 359 billion yuan in 1978, to 8.94 trillion yuan in 2000 (Keping 2009). This economic success requires to be considered in evaluating the impact of poverty on individuals, and the consequences of environmental and ecological degradation. For example, although there were more than one million millionaires in 1997, more than 80 million people were living under the

poverty line of about 200 yuan per year (Keping 2009). With the change from a socialist planned market to a market economy a large number of citizens have for the first time, no access to any form of social security in China (Keping 2009).

Above, the influence of the context which the individual lives in has been considered. The next section aims to explore the influence of such an environment in shaping the ethical character of the citizen through the concept of identity.

Aporia 4. Citizenship

The history of sovereignty has been one defining alterity, originally at the nation-state level, and more recently at the supra-national level. The functional unit of a polity is the citizen. This status of an individual as tied to a political unit is constitutive of a self-identity. Lindahl explains that this identity is reflexive in the way in which the individual constitutes the constituted power and vice versa:

> Whereas the identity of a thing can only be established in terms of what it is, the identity of a human being is also reflexive in that this being relates to itself as the one who acts and who is ultimately at stake in such acts (Lindahl 2007a:6).

In terms of citizenship, the reflexive aspect is developed through the potentially interrelated dimensions of Membership, Identity, Rights, and Participation, which all have a bearing upon each other (Olsen 2008). Such dynamic relations are defining for the citizen, state, and for the formation of groups. Isin (2002) clarifies that these

relationships are not simply polar between inclusory and exclusory, but rather that they are dialogical. Crucially Isin goes on to explain;

> Ways of becoming political, such as being citizens, strangers, outsiders, and aliens, do not exist in themselves, but only in relation to each other (Isin 2002:29).

This basic structure has not changed with the transposition of citizenship to the supra-national level, only the complexity of choice has increased for the citizen as they have to consider an array of multiple identities (Verhoeven 2002). Only the individual can decide the value and emotional significance attached to membership of social groups, which thereby construct their self-image (Tajfel 1981). However, all of these processes tie the individual through membership as a citizen to some collective organisation, or organisations (Olsen 2008).

Where nationalism was a powerful concept in helping individuals conceive of their identity in a social, religious, and political space, European legislation is now putting into question the master identity imposed by the nation-state. The challenge now from globalisation, and advanced capitalism is how to develop a new order. The digital exchange of information as communication and commerce is a useful model to problematize the issues of previous conceptions of sovereignty as governance. Consideration would then need to be given to notions of Membership, Identity, Rights, and Participation across virtual boundaries.

Regardless of the changing structure, it can be seen that citizenship and the dialogical relationships involved are powerful in developing identity. In relation to healthcare in general, and health care and legal professions particularly, Isin believes that the professions purposefully deploy alterity:

> It may also enable us to see "globalization" and "postmodernization" not as given and immutable phenomena, but as strategies deployed by the professions as dominant groups to constitute their strangers, outsiders, and aliens, who while being implicated in these strategies, also attempt to capture and transverse them (Isin 2002: 283).

As previously discussed under the concept of 'Polycentricity', this complex network of relations has real consequences for ethics as human action. Polyanyi's theory seems to tie in well here, for although he was writing about business as an interrelated system, his theory also functions at the individual level:

> Where large numbers are involved, such mutual adjustments must be indirect; each individual adjusts himself to a state of affairs resulting from the foregoing actions of the rest (Polyanyi 1999:170)[100]

Citizenship then creates a specific type of actor, and defines the limits of their role in terms of freedom to act. Isin captures this poetically where he explains that:

> The city is a difference machine because these "characters" are not formed outside the machine and encounter each within the city, but the city assembles, generates, distributes, and differentiates these

[100] Polanyi proposes that for "individuals" we may read "corporations acting as individuals" (Polyanyi 1999).

> differences, incorporates them within strategies and technologies, and elicits, interpellates, adjures, and incites them (Isin 2002:283).

With regard to the legal process, it was established earlier that polycentricity influenced the judges ability to make a judgement, in that when a case was said to have polycentricity the many interrelated consequences were unknown-the spiders-web effect. Equally, the city (or hospital, or state) has been uncovered in its role as determining relationships, and casting the role of actors. In discussing human action Hannah Arendt seems to capture the significance of this network;

> It is in accordance with the great tradition of Western thought to think along these lines: to accuse freedom of luring man into necessity, to condemn action, the spontaneous beginning of something new, because its results fall into a predetermined net of relationships, invariably dragging the agent with them, who seems to forfeit his freedom the very moment he makes use of it. The only salvation from this kind of freedom seems to lie in non-acting, in abstention from the whole realm of human affairs as the only means to safeguard one's sovereignty and integrity as a person (Arendt 1998:234)

Under such negative analysis, citizenship appears to be an aporia as far as ethical action is concerned. Lindahl (2007) found that Kelsen and Schmitt both interpret the 'self' of the self-rule as meaning the rulers and the ruled are the same. These two forms of identity lead to two distinct kinds of questions which both operate at the individual, and collective levels.

In the final section consideration will be given to Kierkegaard's view of identity as selfhood in developing a civil society. Before exploring Kierkegaard's proposal, one

final aporia influencing decision making will discussed; that concerning the affect of a secularizing society upon ethical debate within health care.

Aporia 5. Secularisation as an Influence upon Ethical Decision Making

It was established in chapter 5 that major world belief systems continue to influence ethicists in the process of ethical decision making. In Chapter Five, the review of major world religions and cultures upon bioethics focussed upon hermeneutical challenges. Added to this factor are that patients and their families bring their own individual belief systems, and notions of value when making decisions about health care. The aim of this section is to consider current challenges to some of the major world belief systems, and the potential consequences of this to ethical decision making.

Taylor in analysing 'Latin Christendom' (2007:29) provides an in-depth analysis of Secularization. Similarly, MacIntryre (1967) traces the changing social relations due to laisser-faire ideology, and utilitarianism as part of market forces which dominated secular thought. In questioning the move from having a religious belief to not having one, Taylor sets out three main areas of change (Taylor 2007). Some of these features have been seen in the discussion of Natural law above. According to Taylor, previously the natural world which individuals inhabited had its place in the cosmos and the great natural events were attributed to the Absolute. Secondly, sovereignty – as already discussed - was founded upon the Absolute. Finally, in accord with Weber's expression

of "disenchantment" (Weber 2004), Taylor proposes that the pre-modern condition was to live in this terms negation; an 'enchanted' world (Taylor 2007:26 27).

While it is recognised that the analysis provided by MacIntyre and Taylor are predominantly focussed upon the Christian tradition, the current analysis aims to continue with a global view, where the topic is considered from Kierkegaard's perspective of becoming, which includes becoming an atheist. So it is not so much about any one religion, but rather, about authentic being. Gorski and Altinordu (2008) argue that an approach which incorporates non-Christian religions and non-Western religions is needed to fill in gaps in empirical knowledge, and also to respond to practical and political challenges facing societies which no longer consist of just one or two main religions. However, the approach taken by both MacIntyre and Taylor, their respective findings, and the framework by Taylor are foundational in being able to move on to a more abstract discussion.

Taylor (2007) summarises secularization theory into having three explanatory facets. Gorski and Altinordu (2008) also provide a helpful overview, and add to the complexity of secularization theory by explaining some theories are also concerned about the way the different facets interact. Taylor explains the main structure:

> This has been mainly concerned with explaining various facets of secularity 1 (the retreat of religion in public life) and 2 (the decline in belief and practice), but obviously, there is going to be a lot of overlap between these and secularity 3 (the change in the conditions of belief) (Taylor 2007:423).

Much of the foregoing discussion has considered facets 1 and 2 of secularization in conjunction with sovereignty. In summary they were that the Post-Westphalian structure caused a substantial change in the discourse on the legitimacy of authority. Prior to this sovereignty had a strong theological character (Mac Amhlaigh 2007). The contractualist account from Thomas Hobbes onwards then provided a framework for a secularising shift, where sovereignty was implemented through a social contract.

Secularization has been evaluated in terms of attendance at institutions of religion, and in terms of individuals espousing a personal faith. Chaves (1994) proposes that neo-secularization is most productively conceived of as a decline in religious authority, and as a decrease in the influence of religious values.

In terms of attendance at religious institutions Küenzlen (2009) indicates an increase in Russia and in Yugoslavia. Currently the interest is focussed upon the increased interest in religion in China. Writing in *The Guardian* Weiss proposes:

> The reasons for this boom are twofold. The first is that the Chinese have found Christianity to be a stabilising belief system amid a dramatically changing socioeconomic landscape, which had its previous religious traditions crushed by Maoism and its values questioned after Tiananmen Square. And, secondly, with its obvious western heritage, the rise of Christianity may be linked to a subconscious attack on the norms and values espoused by the PRC[101] – rather like South Korea in the 1980s (Weiss 2010).

[101] People's Republic of China.

Such a change in the grounds of belief reveals a complex view of secularization from the global perspective. As Taylor suggests there appears to be movement between secularization and sacralization:

> Thus my own view of "secularization", which I freely confess has been shaped by my own perspective as a believer (but that I would nevertheless hope to be able to defend with arguments), is that there has certainly been a "decline" of religion. Religious belief now exists in a field of choices which include various forms of demurral other spiritual options. But the interesting story is not simply one of decline, but also of a new placement of the sacred or spiritual in relation to individual and social life. This new placement is now the occasion for recompositions of spiritual life in new forms, and for new ways of existing both in and out of relation to God (Taylor 2007:437).

This complex global situation regarding world religions is challenging to draw together in considering its influence upon ethical decision making. One final comment from Marcel Gauchet (1999) points to a discussion prescient in the work of Kierkegaard. Gauchet (1999) thought that secularisation was the loss of the constitutive or world-forming power from religion, and that the hallmark of religion is the postulate of a supramundane realm. An attempt will now be made to consider this complex view within the confines of Kierkegaard's concept of Christendom.

In his book *Attack Upon Christendom* Kierkegaard distinguishes between Christianity and Christendom (Vardy 1996). Most of the secondary literature on Kierkegaard provides lengthy detail on Kierkegaard's criticism of the Lutheran Church of Denmark (Pattison 1997, Hannay & Marino 1998, Carlisle 2006). Kierkegaard's view of Christendom links to his concept of the *crowd* which would allow the public to

recognise and call themselves Christians en masse. Kierkegaard wanted to ward against religion as a system similar to that of Hegel's philosophy (Carlisle 2006). Kierkegaard wanted individuals to think for themselves and not to just adopt the whole theological framework in an unthinking (Repetition as discussed next) fashion:

> To lack infinitude is despairing confinement, narrowness. It is, of course, a question here only of ethical narrowness and limitation. The world really only interests itself in intellectual or aesthetic limitations, or in the indifferent, which is always what the world talks about most. For worldliness[102] is precisely to ascribe infinite value to the indifferent. The worldly point of view always clings closely to the difference between man and man, and has naturally no understanding (since to have it is spirituality) of the one thing needful, and therefore no understanding of that limitation and narrowness which is to have lost oneself, not by being volatilized in the infinite, but by being altogether finitized, by instead of being a self, having become a cipher[103], one more person, one more repetition of this perpetual *Einerlei* [one-and-the-same] (Kierkegaard 1989:63).

Globalisation, Cosmopolitanism, Multiculturalism, is not a challenge for Kierkegaard's ethical framework because it is an Open system. Many of the aspects about secularization are in accord with Kierkegaard's thinking. Kierkegaard would enjoy Gauchet's (1999) thought that secularisation was the loss of the constitutive or world-forming power from religion, and that the hallmark of religion is the postulate of a supramundane realm. That is, when secularisation is defined as Christendom. Although Kierkegaard was specifically writing about the Christian faith, his main focus was on that singular individual; The authentic self. In relation to ethical decision making, many

[102] In the translation by Howard and Edna Hong (1980) *The Sickness Unto Death*, Princeton University Press. Princeton) they use the term 'secular mentality' rather than 'worldly'.
[103] Hongs-'Number'.

challenges arise from individuals who are entrapped within their religious system, but who have failed to chose themselves. This will be considered in the next section.

Kierkegaard's View of Civil Society

Kierkegaard was concerned with the way individuals related to each other, and in turn how they related to the political structures that ruled their defined territory. This section aims to discuss some of the challenges set out above as *aporiai*, in presenting Kierkegaard's view of civil society.

Certainly the sketch above of the legal, political, economic and religious landscape has some parallels with the foundational crisis of the times that Kierkegaard was writing from (Garff 2005). In many respects Kierkegaard's very writing style demonstrates a contributing aspect to his theory of being. With the use of irony and maieutics,[104] Kierkegaard is able to create space in his role of author with his readers (Westfall 2009). Through the use of pseudonyms, differing opinions in different books being published on the same day, and indirect communication, Kierkegaard states that he deliberately used these techniques in order to assist individuals to think for themselves (Kierkegaard 2009a). The purpose of this was to break away from the crowd and to speak to that single individual (Kierkegaard 2009a). Westfall summarises this by explaining that Kierkegaard lets his students 'discover the truth for themselves' (Westfall 2009:640).

[104] The word maieutics comes from the Greek word *maieusthai* which means midwifery.

At the heart of Kierkegaard's view of civil society is the authentic individual. Chapter Six was prefaced with Kierkegaard's central premise on ontology; that

> Every human being, no matter how slightly gifted he is, however subordinate his position in life may be, has a natural need to formulate a life-view (Kierkegaard 1992b:493).

However, the preceding discussion above has highlighted a range of obstacles in achieving this selfhood, not least the circular economy of exchange, which defines alterity through the difference machine. Such an economy has been seen to be feeble in helping those most vulnerable individuals in time of most need, whether this is vulnerable patients or countries. As introduced in the previous chapter, and emphasised in the discussion above, it seems as if in global economic terms a certain magnitude of injustice to millions of individuals is acceptable in a system 'where the ethical becomes as shy as a sparrow in a dance of cranes' (Kierkegaard 2009b:118).

In contradistinction both Levinas and Kierkegaard place the ethical relation with the other 'prior to any thematization or any concrete relation' (Weston 1994:170). Time and again the discussion appears to fall back to the parable of the Good Samaritan. If presented today with such a case-whether a vulnerable individual or country-both the legal and political systems would demonstrate the limits of responsibility. If the cases from Chapter Five are recalled (where Norris considered the legal responsibility to the pedestrian about to walk in front of a lorry, and the absent minded cliff walker) Norris (2009) explained there was no duty of care because the individual has not assumed any responsibility for the unfortunate victim. Similarly, from a political perspective the

individual would be evaluated from the individual-as-worker status as a function of the market. It is against this backdrop that Kierkegaard's view of civil society will now be explicitly appraised.

The spheres of subjective existence are not hierarchical, and experience gained in one sphere can be helpful in another sphere. However, Kierkegaard did propose that there was progression from the aesthetic to the religious, with a deepening of inwardness, truthfulness and passion as the individual moves towards the ethical and religious spheres (Carlisle 2006). Each sphere of existence also has an increasing appreciation for the actualisation of possibilities (Carlisle 2006). Crucially, both Levinas and Kierkegaard believe that existence occurs, not within immanence, but rather in transcendence. This is crucial due to the consequences of such a view, which was discussed above in relation to Aquinas and the subsequent removal of Natural law. Transcendence is important to the current discussion on at least two levels. Firstly, it provides a unique view as an existing individual from which to consider existence. In discussing how philosophy interprets the I as a particular case of generality, Weston explains the importance of transcendence for Kierkegaard and Levinas where he states:

> But the very structure of this thought for both Kierkegaard and Levinas ignores the first-person position from which the philosopher must himself speak. The essential character of this 'position' is that I am not for myself a particular case of a generality: and it is this which requires for both thinkers a reference to a 'transcendence' which itself precludes conceptuality and which therefore involves us in a paradoxicality when we try to speak about it (Weston 1994:167).

As a consequence of the above then, secondly, transcendence removes boundaries which communities and political systems rely upon, but produce closure towards the other. Thus it is the authentic individual which is at the centre of Kierkegaard's view of civil society.

The authentic individual is the one who has decided to make a project of becoming of his or her self. For those who do not make this choice are said to be in *Despair* because they realise that the actual self is not the true self. According to Kierkegaard the majority of individuals would be in this category of misrelation to their self, in despair. This theory has been critically applied previously to individuals, at this stage in the discussion it will be applied to society. In recalling the collective as a difference machine the struggle to become the authentic self can be envisioned where Kierkegaard proposed:

> A person in despair wants despairingly to be himself. But surely if he wants despairingly to be himself, he cannot want to be rid of himself. Yes, or so it seems. But closer observation reveals the contradiction to be still the same. The self which, in his despair, he wants to be is a self he is not (indeed, to want to be the self he truly is, is the very opposite of despair); that is, he wants to tear his self away from the power which established it. But despite all his despair, this he is incapable of doing. Despite all his despairing efforts, that power is the stronger, and it compels him to be the self he does not want to be (Kierkegaard.1989:50).

In the aesthetic sphere, the difference machine overwhelms the individual and they are unable to be the authentic individual. At the political level the traits of the aesthetic sphere include having a weak sense of self, social conformity, planning for the moment,

and being self interested. There are lots of ideas and possibilities - but like the seducer in Either/Or - there is no commitment. The common good and strategic *telos* is in valuing pleasure, and there is institutionalisation of the construction of the self. The processes of socialisation and institutionalisation remain for Kierkegaard a choice for the individual:

> If you imagine a helmsman in his ship when it is just about to tack, then he may be able to say, 'I can either do this or that', but unless he is a pretty poor helmsman he will also be aware that the ship is still maintaining its normal headway, and so there is only an instant when it is immaterial whether he does this or that. Similarly with a human being; if he forgets to take the headway into account, the moment eventually comes when there is no longer any question of an either/or, not because he has chosen but because he has refrained from choice, which can also be expressed in another way: because others have chosen for him, because he has lost himself (Kierkegaard 1992b:483).

There are two manoeuvres which awaken the individual from the sickness unto death and contribute to Kierkegaard's vision of a civil society. These involve Irony and Repetition. Each will now be discussed in turn regarding their contribution to selfhood, before the final discussion on the ethical sphere.

Genuine community life is predicated upon the authentic individual. Irony is a transition area located within the aesthetic sphere which assists the individual to move into the ethical sphere (Carlisle 2006). It helps the individual by providing a standpoint from which to put into question the prevailing lego-political structures as discussed above. Irony allows the single individual a space from which to teleologically suspend

their absolute attachment to the established order (Dooley 2001). To put into question the deification of the state, and the legitimacy of the difference machine:

> The immediacy of the age of revolution is a restoring of natural relationships in contrast to a fossilized formalism which, by having lost the originality of the ethical, has become a dessicated ruin, a narrow-hearted custom and practice (Kierkegaard 2009c:65).

Through irony the individual can disengage from the state of immediacy. This process can be facilitated by the use of *maieutics* as an educational tool where the individual is set off balance and is being placed into a position to having to think about what the truth may be.

Kierkegaard responds to Socrates and Plato's proposal that truth can be found in recollection, and to Hegel's through mediation; that truth can only be found through Repetition. This concept is important in becoming an authentic individual within society, so some of the complex relevant aspects will be unpacked below.

In order for the individual to gain a new, fresh perspective, which is able to stand back from immanence, this requires transcendence. The transforming aspect here is that the individual no longer relates itself to itself, but now relates itself to the Absolute as an ethical model and ideal (Kierkegaard 1989). From this new standpoint the individual is able to evaluate the world, and re-evaluate past experiences. This in passing has a poetic relevance to the idea of *maieutics* because in discussing Repetition Kierkegaard states the person becomes 'a *new* person (Kierkegaard 1985:18)', and the process as a

'*rebirth* (Kierkegaard 1985:19)'. One relevant further term is worth mentioning here, and that is that Kierkegaard calls the transformation of perspective '*the moment*' (Kierkegaard 1985:19).[105] To summarise this transfer from relating to themselves, to now relating to the Absolute, Kierkegaard explains:

> Inasmuch as he was in untruth and now along with the condition receives the truth, a change takes place in him like the change from "not to be" to "to be" is indeed the transition of birth (Kierkegaard 1985:19).

From 'the moment' the individual gains this new perspective, truth can be evaluated against this act of transcendence, rather than the previous position of immanence. A gulf then opens up here between two ways of knowing. One way is as described above which could be called subjective knowing, and the other which is human or secular knowledge which refers to simply upholding the law-without critical reflection. For Kierkegaard individuals do not have a predetermined identity. Rather, identity is always something yet to be established.

Transcendence allows the individual to chose their self, rather than as being in terms of social roles. By being able to evaluate the legal and political status quo against the Absolute, the individual is able to develop a more responsible perspective, in opposition to the crowd of herd-like status against which Kierkegaard constantly warns;

> But while one kind of despair steers blindly in the infinite and loses itself, another kind of despair allows itself to be, so to speak, cheated of its self by 'the others'. By seeing the multitude of people

[105] All emphasis is in the original for 'new' 'rebirth' and 'the moment'.

> around it, by being busied with all sorts of worldly affairs, by being wise to the ways of the world, such a person forgets himself, in a divine sense forgets his own name, dares not believe in himself, finds being himself too risky, finds it much easier and safer to be like the others, to become a copy, a number, along with the crowd (Kierkegaard 1989: 63, 64).

As has been discussed previously in the clinical cases, only in a synthesis of the finite and infinite, can the authentic individual emerge. The legal cases of Khan, Coleman, and Merelie, have each in their own way demonstrated the consequences of becoming entangled in being as social roles.

Conclusion

This chapter has been concerned with elucidating the dynamics between the ethical individual in relation to the ultimate authority located within the concept of sovereignty. Five different paths were explored as potential frameworks to support ethical action, but each resulted in a fossilisation of the individual into the universalising system.

The structure of the chapter allowed a movement from exploring the ethical issues within the legal cases, out to the same issues at the level of countries. To the recurring themes Kierkegaard provided a recurring singular response which was focused on the authentic self. Although many issues were identified regarding the legal system, it has to be stressed:

> However, neither Kierkegaard nor Derrida considers it possible to dissolve the law. What they do call for is a “reinvention” or a “repetition” of the law, with the aim of making it more responsive to

> the idiosyncratic demands of each particular event. Kierkegaard considers this the way to bring the law to life anew (repetition) (Dooley 2001:235).

Indeed, Repetition seems to be a key concept in helping the individual health care professional gain a key advantage point from which to evaluate ethical dilemmas. Real, practical, teaching strategies were considered, where, for example, Irony can be used to assist the individual to drive a wedge between unreflective social roles, and Repetition. *Maieutics* was also considered as a facilitative educational process in this connection.

Where in previous periods religion and the topic of theology contributed as a guiding force on ethical issues, areas of acute debate within some key world religions appear to render them silent on key current ethical debates. In some of the examples discussed, delay appears a purposeful strategy within church governance in order to keep disparate opinion from causing fissures within the institutions. Although as Kierkegaard has highlighted with the Helmsman, indecision is a decision.

Finally, one of the recurring themes has been the way in which institutional frameworks have relieved their actors of responsibility, regardless of whether that system is the healthcare, legal, political, or theological system.

Chapters Five, Six, and Seven have all engaged with a critical analysis which has reviewed ethical action and has tried to uncover the normative framework. Chapter Eight will consider Existentialism as a potential framework to guide ethical action.

CHAPTER EIGHT: EXISTENTIALISM AT THE IM/PASSE

> For example, it is said that one rues ten times having spoken, for the one time one rues one's silence. And why? Because the external fact of having spoken can involve one in disagreeable consequences, since it is something actual. But to have kept silent! Yet this is the most dangerous of all…The world thinks it is dangerous to venture in this way, and why? Because one might lose; the prudent thing is not to venture. And yet by not venturing it is so dreadfully easy to lose what would be hard to lose by venturing and which, whatever you lost, you will in any case never lose in this way, so easily, so completely, as though it were nothing-oneself. For if I have ventured wrongly, very well, life then helps me with its penalty[106]. But if I haven't ventured at all, who helps me then? (Kierkegaard 1989: 64, 65).

Introduction

The previous Chapters, Five, Six, and Seven have explored the philosophical relationship between ethics and law. In order to do this, the thesis has set up a number of main arguments following a sustained analysis of ethical experience as viewed in the legal transcripts of clinical negligence. Ethical experience has been evaluated against the philosophical writings of, primarily, Kierkegaard, Levinas, and Sartre.

One of the central arguments concluded that there are three contending positions regarding the influence of morals in law. These philosophical views were outlined in the discussion regarding Natural law (Aristotle, Hobbes), Legal positivism (Hart,

[106] In the translation by Howard and Edna Hong of *The Sickness unto Death*, they state '…life helps me by punishing me' (Kierkegaard 1980a: 34).

Kelson), and in the Law as interpretation (Dworkin). Of relevance to this chapter is the complex summary; that this is best seen as a continuum, with the various theorists located somewhere on the spectrum between law as an intersection of law and morals, and the pole position of law as a closed logical system which is separate from morals. The point to highlight seems to be *when* the moral analysis is performed, rather than thinking that legal positivists exclude this aspect. Legal positivists are concerned with the influence of morality on law. However, they

> … do share the view that the most effective method of *analysing* and *understanding*[107] law and the legal system involves suspending moral judgement until it is established what it is we are seeking to explain (Wacks 2005:44).

Placing the analysis at the end of the process as an ethical cleansing of law, has however, a significant effect on the outcome, in comparison to, for example Dworkin who sees the moral and political aspects as intertwined in law.

Another central argument which commenced in Chapter Five, first having provided the central features of an existential approach to responsibility, has explored the constant *Either/Or* regarding the choice of the ethical and the limits set upon responsibility towards the other. This argument has developed through Chapters Six and Seven, and expanded to explore the relationships between law, ethics, and politics, in locating ultimate authority in justice. Crucially, Chapter Seven concluded that the current

[107] Italics in the original.

political structure provides a teleological suspension of the ethical and legal in preference for the political.

The cases of clinical negligence reviewed, have allowed a tracing of the whole legal process from the clinical setting to final legal judgements, including the appeal process. This systematic investigation of the legal process is critical to the current discussion regarding the ethical care of patients, due to the way in which clinical care is regulated by such a legal framework. At the same time, the investigation has achieved some clarification of questions raised in previous chapters. These insights shall be set out first in summary form, before moving on to consider existentialism *per se.*

By observing the end of the legal system, and accounting for the structures of human interaction it has been possible to see the conditions for the realisation of the political-legal system. During the discussion it has been established that Civil law is based upon Case law which involves the authority of legal precedent and legal axioms. The first insight gained from the legal cases concerns law as a closed system of norms. As a normative theory of justice the procedure was followed both in the court system, and in detail during the hearing of a particular legal case. The court system of normative law involves evaluating the facts of the case against the legal framework through the court of first hearing through to the final appeal stage. Within a case hearing, once the *facts in issue* have been heard, the legal hierarchy of authority is followed. It can be recalled that this involves reviewing previous legal cases in an attempt to find the best fitting (similar) case, adhering to the doctrine of legal precedent, applying statute law, following the relevant legal axioms, and subjecting all of these stages to hermeneutics.

Yet, in all of the cases reviewed there was no exact fitting previous case. This poses a challenge to legal positivism such as that previously proposed by Hans Kelsen. That is, in the cases reviewed the law as posited was not followed. While the focus will remain upon the point under consideration, the concept of freedom in the decision making process will be discussed fully at a later juncture.

When the law as posited was not followed, it was observed that often a decision was put off (delayed), referred to another higher court, or a decision was made which had a political *ratio decidendi* such as the case which was said to involve polycentricity. In all of the cases, the law as posited was *suspended.* It appears that in following the legal process that these *particular* cases, precisely because they are *aporia*, have captured something significant. This is in the sense discussed previously regarding *aporia*, that rather than being a dead end to the enquiry, this boundary area in law (inside and outside, nomos and anomie) has become the point about where the whole question turns. That is, how the legal system behaves when presented with a question which does not readily fit the previous legal authority, especially those of a political nature.

What posited law appears to capture in these *aporia* is precisely its inability to respond to the *particular* case. Each case is *other,* requiring an absolutely unique interpretation and a decision based upon *totalized* rules. With the question of justice therefore not answered, it repeats rather like an echo.[108] Such injustice resulting from indecision,

[108] This idea of an echo is developed from Levinas, in that the need for justice has not been met. So the 'call of the *other*' remains until this need is addressed.

Kierkegaard would term the *teleological suspension of the legal*, in preference for the political.

With some of the main challenges identified to an ethical way of being, this chapter aims to respond to some of the problems identified in the current ethico-legal and political structures. It will then consider Existentialism as a potential way of being which will ensure the ethical care of patients. This chapter continues with a critical revisiting of the main themes of existentialism; Freedom/time/repetition/
Selfhood/the moment.

Main Themes of Existentialism: Freedom/time/repetition/selfhood/the moment

Kierkegaard's analysis of the nature of truth is a response to speculative thinking, particularly of Hegel's philosophy. While Kierkegaard critiqued a number of areas within Hegel's philosophy he did respect him, and the truth which Kierkegaard is interested in is ethical or religious truth (Evans 1998). This is a point to clarify as his critique does not apply to other types of knowledge.

Kierkegaard considers scientific methodology as an inappropriate research approach for investigating the human spirit (Kierkegaard 1992b). With regard to ethical and religious knowledge Kierkegaard thinks that people forget that they really exist. In *The Sickness Unto Death* Kierkegaard explores some of the subtleties of losing oneself in relation to existing ethically (Kierkegaard 1989). Deductive reasoning, with its method of moving from an idea out to reality is not truth *qua* ethical knowledge. The distinction can be seen where he states 'A human being thinks and exists, and existence

[*Existents*] separates thinking and being, holds them apart from each other in succession (Kierkegaard 1992a; 332). For Kierkegaard, truth happens when an idea is turned into reality (Dooley 2001). In this way Kierkegaard's philosophy informs people how to live;

> All essential knowing pertains to existence, or only the knowing whose relation to existence is essential is essential knowing. Essentially viewed, the knowing that does not inwardly in the reflection of inwardness pertain to existence is accidental knowing, and its degree and scope, essentially viewed, are a matter of indifference (Kierkegaard 1992a: 197)

Carlisle clarifies the difference between objective and subjective truth in the following way; 'Kierkegaard says that subjective truth is a matter of *how*-how one lives-whereas objective truth is a matter of *what* one knows or believes' (2006: 68).

This appears of relevance to the current analysis of the legal transcripts in that it was previously established, that the judges having considered all of the objective truth through the legal hierarchy of authority (legal evidence, previous legal cases, precedent, and legal axioms), frequently had to make a subjective decision. A similar situation arose in the case involving the use of Herceptin where the research based guidelines (NICE) were overruled by the Health Ministers subjective decision (Ann Marie Rogers) v. Swindon Primary Care Trust ([2006] EWHC 171 (Admin), [2006] EWCA Civ 392.). A final example would be in Brindley v Queen's Medical Centre University Hospital NHS Trust ([2005] EWHC 2647 (QB)) where Professor James did not follow the

guidelines he developed for the Royal College of Obstetricians and Gynaecologists (chapter six).

Kierkegaard's main argument in the *Concluding Unscientific Postscript to Philosophical Fragments* (Kierkegaard 1992a) is relevant to the analysis of clinical decision making, and the legal transcripts, especially where scientific truth is being applied to ethical problems. In ethical matters, Kierkegaard thinks that rather than helping, it can remove the energy from the ethical way of life;

> But all such scientificalness becomes especially dangerous and corruptive when it wants to enter the realm of the spirit…O dreadful sophistry which expands microscopically and telescopically in volume after volume and yet, qualitatively understood, yields nothing but does deceive men out of the simple, profound, passionate wonder and admiration which gives impetus to the ethical.' Kierkegaard 1975: 243, 244,245. (2809)).

Levinas is in accord with Kierkegaard's important argument here, and so both will be considered in now bringing together some of the main themes from the previous chapters, and by drawing out some of the specific consequences for ethics in caring for patients.

Both Kierkegaard and Levinas consider Western rationality as reductive, which when worked out in ontology, epistemology, and metaphysics, is detrimental to ethical behaviour. Levinas explains it as 'Western philosophy has most often been an ontology: a reduction of the other to the same…' (Levinas 2008b: 43). However, some of the

detail is required to be exposed here, in order to outline the consequences at a later point.

The rationalist project, in order to attain objectivity, tries to think of the individual by dissolving their subjectivities into a collective group in order to develop a system. Kierkegaard explains this claim;

> But for the speculating thinker…his task consists in going away from himself more and more and becoming objective and in that way disappearing from himself and becoming the gazing power of speculative thought (Kierkegaard 1992a:56).

At this point it is worth highlighting the overall effect of totalisation, especially in the care of vulnerable patients. This has been a leitmotif throughout the thesis, however the accumulative discussion identifies a human being who is being dissolved, desensitised, and who eventually has *no-self-to-care* for patients.

Existentialism proposes an alternative way to exist as a human being. One which has the concern for the most vulnerable in society as one of the irrefusable demands. Where ethics is prior to ontology. From such a perspective, existentialism will now be evaluated as a potential way to care for patients, and how this would contribute to ontology, epistemology, and metaphysics.

The distinction provided by Kierkegaard regarding subjectivity and objectivity will be sustained in the current discussion, but also with a view later, to use this distinction in the chapter to reconsider *aporia* in an ethical dilemma.

Kierkegaard proposed that;

> Ethically-religiously, the emphasis is again on: *how*...but it is to be understood as the relation of the existing person, in his very existence, to what is said. Objectively, the question is only about categories of thought; subjectively, about inwardness. At its maximum, this "how" is the passion of the infinite, and the passion of the infinite is the very truth (Kierkegaard 1992a:202, 203).

There are a number of key features within this proposal which transpire to be a radical departure from the norm. When Kierkegaard was writing this he was responding to the ancient Greek approach to truth which was seen as *recollection*, and Hegel's logic of *mediation* (Carlisle 2006). In the place of recollection and mediation Kierkegaard placed his key category of *repetition.* Before considering how *repetition* would help an individual free themselves from the totalising system, Levinas' 'ethics of responsibility' will be brought alongside so that both can be considered in tandem.

The *how*, of how one should live, for Levinas is as introduced in Chapter Five, through the call in the *face* of the other. Levinas believes the rationalistic system wants to understand everything, and fears the things which cannot be grasped by this approach. For this reason Levinas is interested in these things which cannot be subsumed, such as culture, religion, and foreign traditions. For Levinas, the *how* is through *alterity*, the call of the other;

> A calling into question of the same-which cannot occur within the egoist spontaneity of the same-is brought about by the other[109]. We name this calling into question of my spontaneity by the presence of the Other ethics. The strangeness of the Other, his irreducibility to the I, to my thoughts and my possessions, is precisely accomplished as a calling into question of my spontaneity, as ethics (Levinas 2008b: 43).

At this point, it is worth recalling the health professionals and managers in the Khan case where Naazish was administered the fatal overdose of potassium, and the Coleman case where the patient's demise was accurately charted, but little action taken. In addition to this it may be worthwhile to recall from chapter four (Whisteleblowing) that one of the main themes arising in the literature was a 'fear of reprisals' when raising concerns. In all of these examples there seems to be a concrete dynamic between the individual and the system. For quite some time now this has been recognised in inquires, and the concept of 'Systems Failure' is used to define such systemic failure (Walshe and Offen 2001, Walshe 2003, National Quality Board 2010). It is valuable to notice the power of totalisation as discussed above. In the Bristol inquiry a consultant anaesthetist (Dr Bolsin) tried on number of occasions-unsuccessfully-to bring to attention the seemingly high morbidity and mortality rate with a certain surgical procedure. In the Report of the Public Enquiry, Kennedy found;

[109] This non-capitalised other is in the original.

> The difficulties he (Dr Bolsin) encountered reveal both the territorial loyalties and boundaries within the culture of medicine and the NHS and also the realties of power and influence (Kennedy 2001: 161).

From this discussion it can perhaps be seen that even the enquires into clinical negligence-precisely because they take an objectivist, rationalistic approach, - look at the system, the *what* rather than the *how*. Within the legal system the concept of responsibility is given a reduced scope of influence, specifically through Tort law, and duty of care which involves consideration of legal proximity. At the political level, responsibility is also demarked geographically, and even within these boundaries in terms of sameness and difference. For Levinas the responsibility is not set out in positive law as obligations, rather the obligation chooses us precisely because of our ability to make a difference. In contrast to the notion of advocacy, with Levinas the face of the other calls to me, and holds me hostage. Responsibility is then, prior, to any laws, language, and ontology. Levinas explains this;

> The relationship of proximity cannot be reduced to any modality of distance or geometrical contiguity, or to the simple 'representation' of a neighbour; it is already an assignation, an extremely urgent assignation – an obligation, anachronously prior to any commitment (Levinas 2008a:100&101).

As a responsibility which is prior to theory, it escapes conceptualisation, or overflows the finite. It does not negate the need for law and knowledge, but rather the height of the other gives purpose for both in this primordial obligation. In existentialism the other puts my being in question and by so doing challenges totalisation.

Existentialism encourages the individual, not to stand against the system, but to critically evaluate it from the perspective of the infinite self. A being in the system, but not part of it. This is then a particular way of being where the individual may have to sacrifice their own personal security within the tradition in order to respond to the call of the other.

One of the challenges to an ethical way of being is in responding to an ever changing horizon. When this question is addressed within speculative thought it is difficult to recollect a response to a novel problem. That is, looking for a future problem in the past. Because *repetition* has an openness on the future, it is more responsive to the novel. Previously the incongruence of exploring a *how* to live question, with a *what* is the concept, was explored and found to be fruitless. Despite Socrates best efforts as a Gadfly the cathartic-*aporia* failed to stimulate anyone to take up the search for knowledge.

Kierkegaard and Levinas develop a concrete way of being a community, based upon the idea of neighbour. Unlike the powerful processes of socialisation and professionalization, existentialism is able to critically review the current situation through the infinite. In this way each patient is unique.

Conclusion

Chapter Seven aimed at locating the ultimate authority in justice. From at ethical perspective, all of the various investigations ended in an impasse where the ethical question was never addressed. This chapter is a continuation from the previous one but

has developed to consider if existentialism could be a potential way through the problem (aporia).

When the law was investigated as a system to provide justice, it was found to suspend ethical and legal matters to give priority to the political discourse. It was then proposed that when justice is not being done by the legal system, the ethical question keeps on calling out-it repeats because it cannot settle. The consequences of this were considered in relation to patients where they never receive a clear answer to the clinical negligence they experienced. This can then result in further investigations and appeals at further cost to the NHS and both the legal and political systems. The wider implications are that the legal decisions made have far reaching implications into the future because of legal mechanisms such as the doctrine of binding precedent.

The work of Kierkegaard assisted in distinguishing between Western rationality and ethics, and also between subjective and objective knowledge. This distinction was then applied to *how* one lives, and *what* one knows, in relation to clinical and legal practice. The argument developed from the previous chapter to highlight the sophistry within law and the extent to which judges make decisions based upon the subjective truth.

One of the results from the discussion in this chapter was the recognition of inadequacy of scientific methodology in addressing ethical problems. The case of the judge overriding evidence based guidelines was used as an exemplar.

The sustained theme of Western rationality as reductive was supported with the somewhat surprising consideration, that evidence based practice has the potential to stultify critical ethical thought, and can in fact remove the passionate wonder of clinical practice.

Kierkegaard uncovers a critical point when he discusses passion, as this is what gives purpose and motivation to work and care for patients. In contrast, the objective truth-on its own- considers categories of thought and as such can create ethical ennui.

Existentialisms contribution to epistemology concluded this chapter in highlighting how *repetition*, rather than *recollection* or *medication* could contribute to the increasing number of novel ethical dilemmas presenting in the future.

The final chapter will draw together the many fragments of existentialism discussed in the thesis in an attempt to propose a coherent way to care for patients.

CHAPTER NINE. CONCLUSION: EXISTENTIAL ETHICS

The Central Claim

The central claim of this thesis is that Existentialism is the missing dimension in providing the most cost efficient ethical health care to patients. This claim has been argued following a critical review of ethical theory which has included; deontology, consequentialism, and virtue ethics, where all were found to be lacking something essential.

A significant point was argued regarding both ethics and epistemology in Chapter Four where the work of Greco and Turri (2011) revealed that in Virtue ethics, and Virtue epistemology, the analysis is reversed in relation to that taken by the other two normative theories of ethics. At the heart of healthcare ethics then, there appears to be a conflict of approaches, or at least, a lack of explanation on how these two main approaches can work together in harmony.

This thesis has therefore aimed to uncover the incongruence of such an approach, and to destabilise the current convention within law, philosophy, and ethics, which is unable to sufficiently acknowledge the experiential dimension of the individual in a particular community or organisation. Moreover, this work has attempted to identify how *de facto* the current philosophical framework actually contributes towards care which falls below a minimum safe –and ethical- level.

This concluding chapter aims to provide a rehearsal of all of the preceding eight chapters by now highlighting some of the key arguments stemming from the research,

which would support the central claim for an existential ethics to be included within the mainstream. Such an ethics would call for a vibrant form of the existent self. However, it is not advocating a radical existentialism. Rather, one which incorporates the key features as outlined by the existentialist writers which includes freedom, authenticity, and responsibility. When applied to health care, the detail has revealed that these concepts involve a pre-philosophical responsibility for the patient (other).

Enfolded within the discussions are two strands of the thesis *qua* thesis. The first has explored the existential dimension of teaching ethics within health care. A sub-strand within this has given consideration to how existentialism could contribute to epistemology, especially an epistemology of ontology. The second strand focussed upon the clinical practice situation, which included the regulating professional bodies. It was here that the experiential dimension was most noticeably minimalized.

Sartre, Levinas, and Kierkegaard all consider three elements in their consideration of existence, namely, the subject, freedom, and the ethical. The central claim of this thesis will now be made explicit, using this triadic structure.

The Subject.

Firstly, the subject. Chapter Six introduced the concept first outlined by Aristotle, and then developed by Kierkegaard, to denote movement (*kinesis*). This is a feature common to all three of the main existential philosophers discussed. For Kierkegaard this involved the individual making the transition from possibility to actuality, and the existential spheres assisted in identifying the movement from the *aesthetic* to the

religious. Existence for Sartre, involves movement from evading the human condition which he termed *bad faith*, towards being authentic. Similar to Kierkegaard, Sartrean ethics requires a clear conception of the self. In the continuum between the *aesthetic* and *ethical*, *irony* provided this starting point for self-awareness, which provided a rupture between the self and the world. The central role of Kinesis in the work of Levinas was introduced in Chapter Two as part of the method, key to this thesis. Levinas's central claim was that the ethical relation is prior to ontology. In other words kinesis, involves realising ethics has priority over ontology.

The implications to the individual health professionals-and also to legal practice would be to propose a radical change to current practice. This would include the way in which ethics is taught; health care is led, and most importantly, the way in which patients are cared for.

Crucially, Levinas has argued that Western philosophy has usually been an ontology (Levinas 2008). With the emphasis placed upon an epistemology of ontology, no prior consideration is given to existence *per se*. That is, the existing individual. Throughout this thesis, the principle concept of the unpresentable *trace*, in Levinas' phenomenology has been highlighted in relation to patient care. Visibility according to Levinas, involves a reduction of the other to my conceptual understanding. This conceptual reduction was considered in relation to the totalising power of an organisation in Chapter Five. Here, Levinas demonstrated that the Other is always irreducible to any category, theme, or concept. Consequently, ethical care is prior to ontology, due to the other having *height*. Such a view appears to contribute towards a

consideration of the emphasis upon teaching concepts, in relation to appreciating the rich pre-ontological (ethical) world.

For Levinas, the ethical relation with the Other is asymmetrical. In professional health care it could be anticipated that the relationship with the patient is asymmetrical due to the nurse or doctor having the superior knowledge and skill in comparison to the patient. However, with Levinas, it is the patient who has *height.* Levinas wants to protect the invisibility of the Other, and the visibility of the Subject. This position only changes when there is the introduction of a third person, as discussed in Chapter Seven in relation to political theory. It is then that both are required to become visible, in order to decide whom to serve first.

The implications for the individual in clinical practice, is the requirement to take on the project of developing an individual self. Existentialism, with its emphasis on existence, has a fundamental concern for the lived experience and subjectivity of those immersed in a practice such as health care and law. For Kierkegaard the individual must make the dialectical move from the aesthetic, to the ethical. The aesthetic stage of existence is characterised by immersion in sensuous experience, giving value to possibility over actuality, it is a distracted stage, and is a despairing means of avoiding commitment and responsibility. In clinical practice it involves being immersed in the current culture, and negating the ability to reflect. Sartre's being-in-itself and bad faith.

Some key aspects then fall from this insight concerning the teaching of ethics, and the Continual Professional Development (CPD) of health care professionals. According to

existentialism, existence precedes essence. So there is no such thing as human nature which would pre-define that some individuals would be more caring or courageous than others. There is only a human condition which is the lived tension between freedom and fact. All individuals therefore have the ability to choose to become more caring, and to become more courageous.

Sartre importantly identified that at the centre of consciousness there is no-thing such as the ego as proposed in psychological and analytical theory. Existentialism then proposes a completely different approach to many other traditional theories which commence with a conception of human nature, and then derive ethical norms from this nature. Consequently the individual's responsibility is not to duty, obligation, nor obedience to some authority. Rather it is in developing a self-for-the other.

The thesis also identified the powerful dynamic that the Other brings to limit freedom- in this case in clinical or legal practice. This finding in the research contributes positively to improving patient care. It could influence education, management, leadership, the psychology of the workplace, and indeed in defining clinical competence. The role of the other in conferring meaning upon the subject requires to be recognised in the way this can limit the Other. At the organisational and societal levels this was highlighted in Chapter Seven by considering the work of Isin on the idea of the city as a difference machine that defined insiders and outsiders. Such a system however, has a serious impact upon patient care, if individual health professionals attempt to be purely what others see in the subject. Previously this was discussed as the sickness unto death, where the individual nurse or doctor was totalised by the system, and where

Sartre proposed that individuals are more than the roles they adopt. Existentialism contributes to the discussion here by highlighting the need for a self-lucidity that is both, self-aware, and also aware of the self in a social (clinical) context. Kierkegaard made this point regarding groups memorable where he proposed that the individual health professional is at risk of existing 'merely in relation to others'. The final outcome of such a quantitative (group, organisational) dialectic is, according to Kierkegaard, 'where the ethical becomes as shy as a sparrow in a dance of cranes' (Kierkegaard 2009b:118). Consequentially, the clinical team has a powerful role in shaping the individual. Equally, the individual health professional has to have a bench mark which transcends the immediate team, and is located in a wider ethical community.

Kierkegaard has emphasised the role of subjectivity over objectivity in ethics, and the importance of the emotions. As outlined above, Kierkegaard's central concern is that the subject should choose to develop a self, in opposition to the crowd which is the untruth. The movement in the existential stages is one of inwardness, towards the ethico-religious stage. Kierkegaard has emphasised the importance of passion in bringing together in synthesis the infinite (freedom) and the finite (necessity). Kierkegaard strongly criticised any abstract theory - but especially Hegel - that does not concern itself with concrete existence, which includes the role of the emotions.

Sartre considered the emotions as having defining power upon objects (patients). The structure for this aspect of his work is to be found where he ties acts and intention

together. Sartre explained that it is through our acts that values spring up, that we discover ourselves in a world – clinical practice - full of demands, in the realisation of our projects.

Equally for patient care, the emotional dimension assists in capturing the rich experience of existence which includes thinking, perception and imagination. Patient care certainly includes providing good arguments, based upon sound evidence, but it also involves motivation (intentionality), where imagination can assist in altering an individual's behaviour. The role of emotion and imagination was discussed in Chapter Four as part of the moral paradigm of virtue ethics, and also in Chapter Eight in relation to repetition which was shown to have openness to the future. The application of this proposal in health care would be principally twofold: In decision making about individual patients, and also as contributing to political theory and an epistemology which views challenges as zetetic-aporia as opposed to cathartic-aporia.

Firstly, imagination is an extended part of perception, of which, emotion is a part. Empathy is important to sensitive patient care. However, empathy involves trying to imagine the patient's situation, or even in trying to envisage the outcomes of various care interventions in the future. Existentialism-as previously discussed can assist considering real or potentially real situations in the future, precisely because it has this openness to the future, and new situations. Deliberation as recall reduces the options open to the patient. Imagination-which includes the emotive aspect can help correct this imbalance but only if it is sufficiently rich and sufficiently inventive (able to transcend the immanent context). For Levinas, this is the call of the other that holds us hostage.

Kierkegaard contributed to facilitating learning in this area through his rich oeuvre which provided examples of deliberative simulation. This pedagogy could be applied to developing health professionals by providing hypothetical scenarios which would help them inhabit the real world.

Creativity and imagination are hallmarks of existentialism because the subject recognises that values are freely created, rather than being discovered. The authentic individual realises that they are not the product of social, hereditary, or institutional demands, so they are open to new meaning. Sartre explains that this includes promoting the freedom of Others (other members of the health care team). The second point regarding emotion, is that decision making without this aspect can also reduce the possibilities to be considered. This was discussed in Chapter Seven where responsibility for the other was proposed as prior to economic calculations.

This rich experience which included perception, imagination, and the role of emotions was also identified in virtue ethics. However, the discussion in Chapter Four concluded that virtue ethics does not discuss how the individual should first choose the virtuous life.

Freedom

While Kierkegaard's work contributes both towards philosophy and theology, he was against organised religion. Overall Kierkegaard was interested in the individual becoming that single individual. By this he meant someone who thought for themselves

and made their own decisions. For this reason he distinguished between Christendom and Christianity, where the latter was where the single individual had a relationship based on faith, and where Christendom was concerned with theoretical proofs about religion, and involved a crowd mentality. Therefore, Kierkegaard cannot be called a religious writer. In fact Kierkegaard set his theology and philosophy free from religious influence. For example, he strongly rejected both Predestination[110] and Determinism, and instead emphasised the freedom that individuals had in choosing their mode of existence. Kierkegaard specifically deployed the different spheres of existence to challenge people who thought they knew what it means to be ethical or religious. However, whether in theology or in philosophy, the main thrust of his argument was regarding becoming that single individual who takes up a stance in relation to their life and world. This is in contrast to being part of the *crowd*.

The freedom proposed is not a radical existential freedom, nor indeed solipsism. Rather it is a freedom which promotes the freedom of other health professionals', responsibility, and it is held *hostage* by the patient.

The Ethical

The ethics being proposed refers to a relationship between oneself and the Other. The

[110] 'It was only when the conception of human freedom developed and was then brought into relation with the conception of divine providence that the doctrine of predestination arose, and had to arise, as an attempt to solve the problem…' (Kierkegaard 1938: 1). 'From every point of view the concept predestination may be considered as an abortion, for having unquestionably arisen in order to relate freedom and God's omnipotence it solves the riddle by denying one of the concepts and consequently explains nothing ' (Kierkegaard 1938: 1)

call of the patient takes priority over ontology. From this primary position the relationship is then characterised by my responsibility for the patient. The critical aspect in delivering this care is through the development of a *self-for-the-other*. A self which is conscious of all the necrosing potential of the system:

> We name this calling into question of my spontaneity by the presence of the Other ethics. The strangeness of the Other, his irreducibility to the I, to my thought and my possessions, is precisely accomplished as a calling into question of my spontaneity, as ethics. Metaphysics, transcendence, the welcoming of the other by the same, of the Other by me, is concretely produced as the calling into question of the same by the other, that is, as the ethics that accomplishes the critical essence of knowledge (Levinas 2008b: 43).

Levinas repositions the focus back onto the individual patient. By doing this there is a reconnection with the meaning of an individual's life and their relations to other people. What is critical here is the engagement with the patient (other) which includes the role of emotion, perception, and imagination. Without this engagement, and without first choosing the ethical-religious, moral theory lies as a sophisticated, paralysed skeleton:

> In relation to their systems most systematisers are like a man who builds an enormous castle and lives in a shack close by; they do not live in their own enormous systematic buildings. But spiritually that is a decisive objection. Spiritually speaking a man's thought must be the building in which he lives —otherwise every-thing is topsy-turvy (Kierkegaard 1938: 156)

The ethics proposed inhabits the real world of patients, and assists health professionals

to engage in this world, as opposed to imaginary examples. However, this thesis has also considered the legal and political influences upon the National Health Service as a system. The next three sections will review some of these influences shaping normative ethics within health care.

The Law as a Means to an End

The legal system influences the way in which health professionals behave. Principally, this is through regulatory legal frameworks, but also through the public consciousness of some paradigm clinical cases discussed in the media. Some of the high profile cases which have been highlighted in the media act as test cases for all involved in health care. In Chapter Four, Dr Stephen Bolsin was considered in regard to whistle blowing. In Chapter Six, Ann Marie Rogers was an exemplar of both a patient-and her Consultant- challenging legal and political limits. While the focus of this thesis has been on health professionals in the clinical context, the thorough investigation of the legal court transcripts led the questioning out into the wider legal and political setting of clinical practice.

Attention was then turned to the freedom of solicitors and the judiciary working in an adversarial system, with the same set of existential philosophical concerns being explored, but this time in relation to notions of justice. The organising question of this part of the thesis was the extent to which morality pervades the legal and political systems. A number of features were identified within the legal system which aimed to provide objectivity and justice. However, once discussion had ceased on the major theoretical approaches towards law (Legal Positivism, Natural law, and law as being

Interpretive), the objectivity of Expert Witnesses was brought into question, the role of Kant's Reflective judgement was highlighted, and the overall legal system was found to have a *telos* beyond the individual patient-as-claimant. From an existential perspective then, law becomes an instrument of economics -as was uncovered through the concept of polycentricity, and politics by way of a constant global redefining of sovereignty. Law, as a means to providing justice to patients is subsumed by the priority of economics and global politics. In Satrean and Kierkegaardian terms, the legal system does not have autonomy or *authenticity* to itself. For Levinas, law and politics would be evaluated as being prior to ethics in the current convention.

Solicitors as a Means to an End

Within the legal system tensions were identified between the individual solicitor working within a team representing the client. For example, in the Naazish Khan case the individual solicitor and the legal team would have had to defend the NHS Trust, even when it knew the Trust was guilty of clinical negligence. In this situation, the solicitor must deploy all of his legal expertise in defending a guilty client. The final example on this theme would be the questionable investigative approach of the Coroner in the Goodson case (Chapter Six). These examples raise further questions about the administration of justice. In particular, regarding the individual solicitor being able to develop an authentic self in the complex set of duties owed to the client, court, the legal system, and to the public interest, and the extent to which solicitors are also instruments (means to an end, as opposed to ends in themselves) within the system. In existential terms, levelled.

It was within the context of the adversarial nature of Tort law that the concept of advocacy was first discussed. Solicitors then are in a challenging situation regarding their ethical behaviour. That is, it is sometimes necessary of the role as solicitor to be partisan. While some of the main arguments for this adversarial role were considered, concern remained when there was the possibility that successful partisanship could subvert justice. The potential for health care is that solicitors could discredit truthful patients, health professionals, and expert witnesses. As a consequence this perverts the possibility to learn from the clinical mistake, to rectify system failures, and for the law to provide norms which could influence ethical behaviour. In other words, it would be difficult to understand the rationale (obiter dictum) of the case, and even more significantly, the consequences of any legal precedent (ratio decendi) set out in such cases.

However, advocacy (partisanship) is not something an individual solicitor can choose. It is part of the structure of the legal system itself. It can potentially have major repercussions for justice precisely because of the important role solicitor's play. This includes from the outset in the court of first hearing, when the facts are presented from both parties. Since higher courts are reluctant to question this evidence, it is this information which structures the later legal arguments.

It seems then as if advocacy requests individual solicitors to suppress their own concepts of truth and justice through loyalty to the client, and by so doing serving the wider ends of justice, and the public good. Such an approach allows the solicitor to support individuals who otherwise would not be able to present their case in legal terms.

Kierkegaard would view such a position as the *aesthetic stage*. This is because the individual solicitor is subsumed by the legal system. In Sartrean terms they have defined themselves by their role, so they are in *bad faith*. They are unable to choose to develop an *authentic* self for the other. This discussion concluded with Sartre's distinction that our individuality becomes subsumed in plurality, and along with it the dissolution of being responsible for my I.

The Judiciary and the Changing Constitution

Since the legal system influences the ethical behaviour of health professionals, the thesis also identified some of the main changes to the role performed by judges. One of the main reasons for doing this was to review what had happened in the past, in the hope of viewing how the judiciary may function in the future. With the explicit realisation that the laws the judiciary make, precedent set, and the rulings announced, will all affect the way health care is delivered for some considerable time into the future. At this juncture some of these findings will be summarised.

Judges have moved from the rule of law (posited) to a role which now has a greater moral and political aspect, and therefore law as being more interpretive. This was argued through the investigation of sovereignty, where Dicey outlined the doctrine of the supremacy of Parliament. Two main themes were discovered here, the first being that the judges had expanded their role to include politics. An example of this was given in the *Wednesbury* principle where judges had reduced the role of the executive, and at the same time had increased their own involvement into the political sphere. It will also be recalled that in the Ann Marie Rogers case, the judge granted permission to

apply for judicial review and ordered the NHS Trust to fund and provide the Herceptin. Secondly, the doctrine of the supremacy of Parliament was also discovered to be undermined by European jurisprudence. Both of these changes were seen to increase the judge's role in morals and politics, in a way not previously involved. This point was confirmed as accurate by Deakin et al (2008:8).

With the fact confirmed that the judiciary is now more involved in the moral and political aspect of law, the closed nature of the legal system can then be seen in how it makes decision making very difficult for judges. That is, the legal system *qua* system suffers from a significant time lag, and an epistemological incoherence. Each of these summary points will now be outlined. First the system lag.

Legal authority is derived from reference to legal axioms, statutes, legislation, precedent, and previous similar court cases. Judges are promoted from solicitors serving as instrumental to the system as discussed above. Statute law, legal precedent, and indeed the European Convention on Human Rights (ECHR) are all historical-relative to the novel questions facing judges. Some of the main examples were Donoghue v. Stevenson (1932), Wednesbury (1948), ECHR (1950), and Bolam (1957). Additionally, it was recognised that the values fossilised in such legal authority would differ from current values. From a hermeneutical perspective, it is a challenge to apply the texts to the judges' now expanded horizon.

Secondly, posited law is based upon an epistemology of recall. However, with judges

being asked more frequently for answers to complex moral and political questions which are debated in the media and wider society, there will be a greater requirement for Kant's Reflective judgement, and creativity and imagination in judicial decision making. The current convention leads to indeterminate decisions. Lord Rawlinson who was a former Attorney General explained that in his previous fifty years of experience, he has never known such antagonism as there is currently, between the judiciary and the executive (King 2009:143).

Overall, the argument concluded that in the new landscape of Rights, the judiciary were now more involved in moral philosophising. The traditional legal approach of applying statute and categorising judgements as correct or incorrect, is less appropriate for a moral and political discourse concerning value laden questions.

The Ethical Community

With some of the main challenges identified in ethical decision making –in health care, law and politics- the focus then turned to considering existentialism as a potential way to resolve some of the incoherence currently seen in ethics, ontology, jurisprudence, politics and philosophy.

The closing chapters of the thesis presented the existential view of civil society, or envisioned how such an ethical community would exist. Nicol's definition of politics can help to draw these arguments together where he proposed:

> For our purposes, politics can be viewed as a way of handling conflicting choices between a multiplicity of moral maps, struggling with fundamental questions of how life should be lived. It is an ongoing struggle between competing visions of the common good, in which different ideological groups engage in a quest for competitive advantage (Nicol 2006:722).

Levinas and Kierkegaard have provided a critique of politics which is not to reject political rationality, rather it is to emphasise the authentic being, which is foundational to politics, and a just polity. Ethics is prior to ontology.

The concluding argument identified the main dynamic of scientific method –whether in health, law or politics-as one of levelling. The end of this method is conclusiveness where everything must be defined by its terms. This can then mean that the system-whether political, legal, or educational-can define morality relative to the historical situation (*epoch*) it happens to be in. This was discussed in relation to the NHS as a quasi-market economy.

With the main legal and political influences upon the National Health Service identified, the final section below aims to bring the discussion to a conclusion in the form of a proposal for existentialism within health care.

Existential Ethics-The proposal for Health Care.

Existential ethics emphasises the pre-theoretical aspect in caring for patients. That is, it appreciates the individual and their difference prior to any conceptualization which has

the potential to reduce individual difference to sameness. Also completely intertwined is the foundational belief that the relationship between the health professional and patient is asymmetrical. We are already captivated by their presence in a non-preferential care towards them.

This view has parallels with virtue ethics in the way both recognise the pre-theoretical. Virtue ethics has much to offer in appreciating this pre-theoretical engagement with the patient with its rich evaluation which includes a role for the emotions and perception. Both existentialism and virtue ethics contribute towards an argument for more of a balanced approach to establishing the truth about patients. As previously argued in this thesis, virtue epistemologists place virtue as foundational. This manoeuvre assists in bringing the real, lived world of the patient and morality closer together. Unlike formulae or rules, the virtues do facilitate health professionals on how to act and feel when confronted with the everyday questions of clinical practice. For Kant there is an unbridgeable gulf between our human perspective and objective reality. Virtue ethics and existentialism in contrast, place an emphasis on the subjective truth for the patient and as part of the lived world of the health professional. As such they both engage with moral practice. The challenge for the other two normative theories is in providing an account which is causally adequate if it is unable to capture the lived experience of patients or the subjectivity of those involved in the moral practice of caring.

The practical proposal established within existentialism is that consideration should then be given to the way in which ethics is taught, and an epistemology which gives

primacy to concepts. With the pre-theoretical world of the patient being such a rich milieu to learn from rather than to impose theoretical frameworks upon. This could be a particularly helpful pedagogy in the health professions to facilitate professionals to inhabit the real world of patients. Part of this approach would be to firstly emphasise the pre-theoretical in caring for patients, and also how this approach would contribute towards epistemology, particularly, health care research.

Levinas provides a structure, to simplify and systematize the pre-theoretical in an approach to caring for patients. That is, that we are already obligated to the patient. Additionally, Kierkegaard identifies the type of (clinical) existence health professionals would have in the *aesthetic* sphere of being. Helpfully, this provides detailed descriptors of beliefs, behaviours, attitudes, and examples of clinical practice (ritualized). Kierkegaard also details how *irony* can be used as a teaching strategy to assist the individual health professional to develop an *authentic* way of caring for patients.

Kierkegaard uses a number of literary techniques which could be used to facilitate learning to develop an authentic self. With the use of pseudonyms, the reader does not know the opinion of the author, so they are encouraged to think for themselves. Kierkegaard developed this technique by publishing two books at the same time, each with differing arguments on the same topic. This could be applied in a practical way with the use of autobiographies such as 'The Diving-Bell and the Butterfly[111]' which

[111] Bauby Jean-Dominique (2008) The Diving-Bell and the Butterfly. (Translated by Jeremy Leggatt). Harper. London.

allows students to witness a patient's world after suffering a massive stroke, and being left completely paralysed.

Deontology and consequentialism evaluate morality against the acts and beliefs carried out by a health professional. Foundational to Kantian deontology is reason, and utilitarianism is based upon what everyone desires. These respective bases are contrary to capturing and appreciating the pre-theoretical world of the patient. However, virtue ethics does capture the pre-theoretical in ethics and virtue epistemology because it places virtue as foundational. From the foregoing discussion in the thesis it appears that Existentialism has the ability to bring all three normative theories together. Firstly by emphasising the pre-theoretical, and secondly by foregrounding the need of the individual health professional to choose an *authentic* way of being. It is this existential dimension that existentialism contributes to the proposal.

This thesis has run a double narrative consisting of exploring ethical decision making in the NHS, and also on the legal concept of clinical negligence. The explicit purpose of this was to ensure that the theory was explored and developed, grounded upon everyday clinical NHS practice, which includes legal and political influences.

The existential theory has identified the process of totalisation at the individual and organisational level within healthcare. Levinas explained how this reductive rationalism was founded upon a reduction of difference within health professionals, to sameness. Similarly, virtue ethics identified the importance of exemplars in providing

good examples of ethical care. Both theories then supported the discussion on the power of the group in influencing the quality of care. Kierkegaard however breaks the circuitous argument of constituting and constituted by placing the single individual at the heart of an ethical community. The focus is then upon developing *authentic* individuals who have chosen the ethical. The power of this process has been witnessed in the legal transcripts where exemplars can influence the quality of care in a negative or positive way.

Managers and leaders within the NHS have a crucial role in deciding how rationalism can be prevented from being deified in the delivery of ethical health care. There is an important role for economics and politics, but left on their own, Levinas has identified, they bear a tyranny. In contrast, existentialism deduces an ethical structure which is irreducible to totality. That is, in the irreducible ethical responsibility to the other. Existentialism does not want to reject the order of political rationality, but rather to do a work for it. The proposal is that ethics is ethical for the sake of a transformed conception of society, law, and politics.

Unlike the normative theories discussed, existentialism encourages the individual to think and decide for themselves as opposed to basing their actions upon duties. When the concept of sovereignty as ultimate authority was explored, it was discovered to be in a state of flux. Equally, when the legal system was considered as a reference for norms, many of the decisions and rulings were indeterminate. In such a political climate it seems as advantageous if health professionals can make decisions which are

open to the future developments (*repetition*), but can, importantly, also justify their moral practices on an individual basis.

This thesis has highlighted many of the features in deontology, consequentialism and virtue ethics, as applied in the NHS. From this strong links have been made with the existing moral domain of health care practice. This thesis has sought to argue that what is missing from these approaches to ethical decision making in the NHS, is the existential dimension. This is not to say that existentialism seeks to oust normative ethics from healthcare education, staff development and practice. Rather it seeks to strengthen it. It seeks to do this by placing the individual at the centre, as the ethical progenitor rather than the obedient servant to systemic and often incongruent forces.

An existentialist ethics is not a solo player. It seeks to bind normativity with a sense of the Other to which normativity is obligated. That said, it has to be acknowledged that there are certain challenges to this approach. The first of these would be that it is a tough call to invite the individual to be elevated above the collective. Moreover there is perhaps a danger that ethical decision making from an existentialist perspective can be reduced to individual predilection, or even worse, solipsism, and not always with the best of results. But that is not the argument. Rather, the argument is at once both modest and strong. It is that without an ethical sense of self for the Other, we are lost to our own subjectivity, our own freedom, our own ethics. Further research is needed in this existentialist area, probably qualitative and with import. I have sought here to introduce existentialism back into the family of ethical decision making in the NHS.

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APPENDIX 1.

KIERKEGAARD'S STAGES OF EXISTENCE.

Aesthetic Sphere:	*Boundary zone*	**Ethical Sphere:**	*Boundary zone*	**Religious Sphere:**
Characterised by;		Characterised by;		Characterised by;
self-interested		world of social responsibility.		only understandable within the individual's relationship with the Absolute.
very weak sense of self.		serious engagement with the Either/Or of our selves. strong sense of self.		surrenders strong self of self.
uninterested in 'the ethical'. standing apart from 'the universal'.	***Irony***	takes the ethical sphere seriously 'the universal'.	***Humour***	faith replaces the ethical or the universal.
lacks freedom-no power to act or become something.	*Taking oneself more seriously*	serious engagement with choice. chooses good and evil/or excludes them.	*Taking oneself less seriously*	involves understanding that one is not self-sufficient.
immersed in the world of immediacy. life of man in his 'natural' state. immersed in the world of pleasure. psychically disjointed. personality is fragmented. intellectual reflection-indifferent to the thinkers reality only value is pleasure. seeks novelty. avoids commitment. rejects social conventions. 'The Seducer'		duty is to 'exteriority'-external, social world. world of human morality. duty & obligation. Marriage.		faith is unique to each individual. paradox, inaccessible to thought. not communicable with others. individual 'excluded' from the normal' social world. individual sets himself apart as the particular above the universal 'interiority'.

Table 9. Kierkegaard's Stages of Existence. Developed from Carilise (2006) and Earnshaw (2006).

APPENDIX 2. WHISTLE BLOWING-SEVEN MAIN THEMES IN THE RESEARCH LITERATURE.

1	Major theme identified in the Whistleblowing literature; ***REPRISALS, RETALIATION, CONSEQUENCES & CENSURE.***	Reference
	Fear of reprisals'	Gobert & Punch (2000)
	Retaliation'	Yamey (2000)
	Made to suffer consequences of making concerns known'.	Hunt (1995)
	P.I.D.A. 1998-Conclusion that a doctor acting today as Dr Bolsin did would not be protected by PIDA.	Dehn (2001)
	"There is a real fear among junior staff (particularly amongst junior doctors and nurses that to comment on colleagues, particularly consultants, is to endanger their future work prospects"	p.273 paras 28-29 Learning from Bristol (2001).
	Dr Koos Stiekema-huge damages against him for whistleblowing on pharmaceutical company-£550.000.	Sheldon (2002)
	Significant damage to their careers' Dr Peter Dawson-after raising concerns about the safety of patients.	Dyer (1999b)
	Graham Pink & Helen Zeitlin-both lost their jobs after raising their concerns.	Vickers (1999)
	What is particularly alarming about this case is that, even after it became apparent that many children had possibly died unnecessarily as a result of the alleged incompetence of the two surgeons, there was still an abundance of censure for Stephen Bolsin.	Klein (1998)
	Fear of reprimand may be a factor in preventing nurses reporting incidents which were a potential risk to patients, whether or not they themselves were responsible.	Walker & Lowe (1998)
	Research with whistleblowing professionals point to their feelings of fear & vulnerability, together with a conviction that nothing would change anyway.	Hunt & Shailer (1995)
	the courage, persistence, and career sacrifice required of a person who is prepared to step out of line in the interests of patients have been clearly shown	Dyer (1998)
	Main reason for nurses not whistleblowing 'fear of retribution'.	Firth-Cozens et al (2003)
	Dr Nancy Olivieri-professional competence, personal lifestyle and mental stability all brought into question for whistleblowing on adverse data on a drug.	Schafer (2007)
	Dr Aubrey Blumsohn (Sheffield university) punished with demotion, suspension &/or dismissal.	Baty (2005)

2	Major theme identified in the Whistleblowing literature. ***PERSONAL EXPERIENCES/PSYCHOLOGICAL IMPACT***	Reference
	Experiences of distress, isolation'	Hunt & Shailer (1995)
	Economic & emotional deprivation'	Hewison & Sim (1998)
	Victimisation' Personal abuse'	Leannane (1993)
	Ostracised by Co-workers'	Vinten (1994)
	Stephen Bolsin-he emigrated to Australia in 1996 because he felt so ostracised by the British Medical establishment.	Dyer (1999a)
	94% of whistleblowers & 92% of non-whistleblowers suffered stress-related emotional problems-anger, anxiety, disillusionment. Non-whistleblowers suffered a higher percentage of emotional health problems, especially feelings of guilt, shame, and unworthiness.	McDonald & Ahern (2000).
	Trust, experiencing intimidation and ostracism by other members of staff.	CHI (2000)

3	Major theme identified in the Whistleblowing literature. ***CLOSED DOORS, SECRECY & SILENCE***	Reference
	things best dealt with in private & behind closed doors' culture of openness discouraged'	Smith (1994)
	Public Interest Disclosure Act (1998)- disclosure must be made in 'good faith'. (May prevent cases being disclosed).	PIDA (1998)
	Good faith'-"mixed motives may be very easy to attribute to any potential whistleblower and would prevent protection under this section" free speech has probably never existed within the NHS'.	P.141 para 194. Learning from Bristol (2001). p.1644 (1994)
	Ritchie found 'considerable reluctance' amongst nursing staff to cooperate with her Inquiry into Rodney Ledward. Some nurses refused to attend it at all, and one who did was told by another nurse 'more the fool you'.	D.O.H. (2000) Wakefield et al. (1999)
	It is known that considerable under-reporting of error takes place.	Firth-Cozens & Greenhalgh (1997).
	There is a tension between 'Confidentiality' and 'Public Interest'.	Gobert & Punch (2000)
	Duty of confidentiality vs. Duty of care.	White (2006)

4	Major theme identified in the Whistleblowing literature. ***NOT LISTENED TO***	Reference
	Unheard warnings are particularly worrying'.	Treasure (1998)
	Consultant anaesthetist in Bristol "blew the whistle" but was disregarded.	Irving,Berwick,Treasure (1998).
	Reviewing the **eight critical occasions** when Dr Bolsin raised his concerns'.	Dehn (2001) P1.
	Research with whistleblowing professionals point to their feelings of fear and vulnerability, together with a conviction that nothing would change anyway.	Hunt & Shailer (1995)
	endemic feeling' among nurses that 'nothing could be done'.	Davidson (1998)
	Twenty years of oral and written expressions of concern by Dr McIndoe.	Cartwright (1988)
	Failure among management to listen to the concerns of student nurses led to the sustained abuse of patients.	CHI (2000)
	Whistle blowers had an extremely difficult time within the Trust, experiencing intimidation and ostracism by other members of staff.	CHI (2000)

5	Major theme identified in the Whistleblowing literature. ***DYNAMICS OF POWER***	Reference
	The difficulties he (Dr Bolsin) encountered reveal both the territorial loyalties and boundaries within the culture of medicine and the NHS and also the realities of power and influence.	P.161. para18. Learning from Bristol (2001).
	He was also concerned that both Organons' arbiters had links with the company and, he felt, could not be guaranteed to give an entirely independent view'.	p.1240 Shelson (2002)
	Sir Donald Irvine acknowledges there is still a long way to go in tackling the issues of poor medical performance head on'.	Medicopolitical Digest (1999) P.1505
	Wrongdoing is more likely to be terminated when whistle blowers have greater power-reflected in legitimacy of their roles and the support of others.	Miceli & Near (2002)
	Cultural differences. Chinese are more likely to report unethical acts of peers than Canadians.	Zhuang, Thomas & Miller (2005)
	Organisations are deeply threatened by what Kant called ethical autonomy (Mündigkeit).	Alford (1999)
	Civilian status demonstrates significant negative relationships with whistle-blowing.	Rothwell & Baldwin (2006).
	Both the patients and nurses stated that for reasons of personality, not all nurses wanted to advocate.	Vaartio & Suominen (2006).

6	Major theme identified in the Whistleblowing literature. ***EXTERNAL CONTROL/EXTERNAL MORALITY***	Reference
	The General Medical Council 'Duties of a Doctor' now places a professional responsibility on doctors to report a colleague suspected of being unfit to practice.	GMC (1998)
	Following Bristol, plans to publish hospital mortality league tables. Introducing Commission for Health Improvement (CHI) to inspect hospitals.	Blumenthal (1996)
	UK Consensus Statement on undergraduate teaching of medical ethics and law, recommends whistle blowing as a core curricular topic.	Consensus Statement (1998).
	Kohlberg (1975) defined six stages, claims the majority of professional people respond to ethical dilemmas at Second level-Conformity to majority behaviour.	Kohlberg (1975)
	McAalpine Level 1. Traditional response, in which response focussed on obedience to others. Only Level 3 challenges unethical practices.	McAlpine et al. (1997).
	Current health care systems continue to promote and reward 'traditional' behaviours in nurses, and that nurses feel powerless to alter the status quo.	Erlen & Frost (1991). McDonald (1994). Mohr (1996) Corley & Goren (1998)
	Whistleblowers agreed more strongly with the advocacy statements and non-whistleblowers agreed more strongly with the traditional statements-deference to the doctor.	Aahern & McDonald (2002).
	More first-year students felt that they should report another students misconduct to faculty, this proportion declines over the years.	Rennie & Crosby (2002).
	Nurses who blew the whistle on misconduct tended to support the beliefs inherent in patient advocacy, while non-whistleblowers retained a belief in the traditional role of nursing	Ahern & McDonald (2002)

7	Major theme identified in the Whistleblowing literature. ***INTERNAL CONTROL/INTERNAL MORALITY***	Reference
	ability to self regulate is integral to the definition of a profession.	Calman (1994) Boland (1995)
	little improvement in students performance as they progressed through the medical curriculum, in terms of their proposed behaviour on meeting the whistle blowing scenario. Reason for this was thought to be student's own personal values/morality.	Goldie et al. (2003)
	In the undergraduate setting there is a responsibility for training in health care professionalism, which involves self-regulation.	Jennings (1991).

APPENDIX 3. Overview of the Legal Process.

Case;	*Chester v Afshar*
Appellate History;	Queen's Bench Division Chester v Afshar **Affirmed by** Court of Appeal (Civil Division) Chester v Afshar [2002] EWCA Civ 724; [2003] Q.B. 356 **Affirmed by** House of Lords Chester v Afshar [2004] UKHL 41
Legislation Cited;	
Significant Cases Cited;	Chappel v Hart [1999] Lloyd's Rep. Med. 223 Fairchild v Glenhaven Funeral Services Ltd [2002] UKHL 22 Bolam v Friern Hospital Management Committee [1957] 1 W.L.R.
Judgement;	[2002] Court of Appeal (Civil Division) His Honour Judge Robert Taylor Lady Justice Hale Sir Christopher Slade Sir Denis Henry
Final Decision;	Appeal dismissed Application for appeal to the House of Lords- refused.
Judgement;	[2004] House of Lords. Lord Bingham of Cornhill-Allow Lord Steyn-Dismiss Lord Hoffman -Allow appeal-dismiss action Lord Hope of Craighead-Dismiss Lord Walker of Gestingthorpe-Dismiss
Final Decision;	3; 2 Dismiss the Appeal.

Table 1. Chester v Afshar.

APPENDIX 3. Overview of the Legal Process.

Case;	*Gregg v Scott*
Appellate History;	Court of Appeal (Civil Division) Gregg v Scott [2002] EWCA Civ 1471 Affirmed by House of Lords Gregg v Scott [2005] UKHL 2
Legislation Cited;	Administration of Justice Act 1982 (C.53) S.4. Fatal Accidents Act 1976 (C 30) S.1. Fatal Accidents Act 1976 S.1. (1). Supreme Court Act 1981 (C.54) S.32A.
Significant Cases Cited;	Fairchild v Glenhaven Funeral Services Ltd. [2002] UKHL 22 Hotson v East Berkshire HA [1987] A.C. 750
Judgement;	Lord Nicholls of Birkenhead - Allow Lord Hoffman - Dismiss Lord Hope of Craighead - Allow Lord Philips of Worth Matravers - Dismiss Baroness Hale of Richmond - Dismiss.
Final Decision;	3; 2 Dismiss the Appeal.

Table 2. Gregg v Scott.

APPENDIX 3. Overview of the Legal Process.

Case;	Hotson v Fitzgerald and Others Queen's Bench Division [1985] 1 W.L.R. 1036
Appellate History;	**Queen's Bench Division** Hotson v East Berkshire HA [1985] 1 W.L.R. 1036
	Affirmed by Court of Appeal (Civil Division) Hotson v East Berkshire HA [1987] 2 W.L.R. 287
	Reversed by Hotson v East Berkshire HA
Legislation Cited; **Significant Cases Cited;**	Administration of Justice Act 1982 (c.53) s.3 Administration of Justice Act 1982 (c.53) s.3(1) Barnett v Chelsea and Kensington Hospital Management Committee [1969] 1 Q.B. 428 Clark v MacLennan [1983] 1 All E.R. 416; (QBD) Davies v Taylor [1974] A.C. 207 Kenyon v Bell
	1953 S.C. 125 Latchford v Spedeworth International (1984) 134 N.L.J. 36; (QBD) McGhee v National Coal Board Robinson v Post Office [1974] 1 W.L.R. 1176
	Swanson v Hanneson (1972) 26 D.L.R. (3d) 201; (0) Sykes v Midland Bank Executor & Trustee Co Ltd [1971] 1 Q.B. 113; [1970] 3 W.L.R. 273; [1970] 2 All E.R. 471; (1970) 114 S.J. 225; (CA (Civ Div)) Sykes v Midland Bank Executor & Trustee Co Ltd [1971] 1 Q.B. 113

Table 3. Hotson v Fitzgerald.

APPENDIX 3. Overview of the Legal Process.

Case;	*Denise Lynn Merelie v Newcastle Primary Care Trust* *Denise Lynn Merelie v Newcastle Primary Care Trust & Others*
Appellate History;	[2004] EWHL 2554 (QB) Justice Eady-Dismiss the claims in both actions led by Merelie [2006] EWHL 150 (QB) High Court of Justice Queens Bench Division. Mr Justice Tugendhat [2006] EWHC 1433 (QB) Mr Justice Underhill-Application for permission to appeal - refused. [2007] EWCA Civ.171. Supreme Court of Judicature. Court of Appeal (Civil Division), on appeal from the High Court of Justice Queen's Bench Division- Lord Justice Pill- Application to appeal -refused.
Legislation Cited;	Employment Rights Act 1996 Part iv. Management of Health & Safety at Work Regulations 1999 (S.1. 1999 3242) reg.3 Protection from Harassment Act 1977 S.1. Protection from Harassment Act 1977 (c.40) S.1. Protection from Harassment Act 1977 (c.40) S.7. Human Rights Act 1998 (C 42)
Significant Cases Cited;	Malik v Bank of Credit and Commerce International SA [1998] A.C. 20 Horrocks v Lowe [1975] A.C. 135 *Bolitho and Others v City and Hackney Health Authority*
Appellate History;	Court of Appeal (Civil Division) [1993] P.I.Q.R. P334 **Affirmed by** House of Lords
Legislation Cited;	
Significant Cases Cited;	Bolitho (Deceased) v City and Hackney HA [1998] A.C. 232 Bolam v Friern Hospital Management Committee [1957] 1 W.L.R. 582 Hunter v. Hanley [1955] S.L.T. 23.
Judgement;	[1993] P.I.Q.R. P334 Court of Appeal. Lord Dillon-Dismiss Lord Farquharson-Dismiss Lord Simon-Brown-Allow
Final Decision;	2;1 Dismiss the Appeal Leave granted to appeal to the House of Lords
Judgement;	[1997] 3 W.L.R. 1151. House of Lords. Lord Browne-Wilkinson-Dismiss Lord Slynn-Dismiss Lord Nolan-Dismiss Lord Hoffmann-Dismiss Lord Clyde-Dismiss
Final Decision;	Unanimous-Dismiss the Appeal
Judgement;	Supreme Court of Judicature Court of Appeal.
Final Decision;	Appeal refused.

Table 4. Merelie v Newcastle Primary Care Trust.

APPENDIX 3. Overview of the Legal Process.

Case;	*R.(on the application of Rogers)* *v Swindon NHS Primary Care Trust*
Appellate History;	[2006] EWHC 171 (Admin)High Court of Justice Queen's Bench Division Administrative Court Reversed by; [2006] EWCA Civ 392 R.(on the application of Rogers v Swindon NHS Primary Care Trust Court of Appeal (Civil Division)
Legislation Cited;	National Health Service Act 1977 (C.49) National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (S1 2002 2375)
Significant Cases Cited;	R. v North Derbyshire HA Ex p. Fisher (1998) 10 Admin. L.R. 27 R. v North West Lancashire HA Ex p. A [2000] 1 W.L.R. 977
Judgement;	[2006] EWHC 171 (Admin)High Court of Justice Queen's Bench Division Administrative Court The Hon. Mr Justice Bean;
Final Decision;	Sir Anthony Clarke MR; Lord Justice Brooke Vice President; Lord Justice Buxton; Policy adopted by the PCT was irrational and unlawful

Table 5. R. (Rogers) v Swindon NHS Primary Care Trust.

APPENDIX 4. Denise Lynn Merelie. Complex Legal Case History.

Merelie v. Newcastle Primary Care Trust-Summary of events.

(Claimant has a history of poor conduct to both patients and staff prior to 1999.)

October 1999.
Claimant lodges a grievance against Mr Ferguson.

22 November 1999. (1).
Tracey Welbury (dentist) letter to Mr F.re Claimants 'unprofessional conduct at Benwell primary school'.

25 November 1999. (2).
Helen Nagaj (dentist) letter to Mr F. re Claimants 'fitness to practice'.

14 March 2000.(3)
4 Dental nurses lodged complaint under formal Grievance procedure against the Claimant.

March 2000. (3).
Written statements from nurses supporting Grievance.

Claimant obtains statements from other nurses to vindicate herself.

August 2000.
Claimant continue to solicit for supportive statements.

September & October 2000.
Disciplinary investigation.

30 January 2001.
Claimant writes to Trust making formal complaint against 4 nurses & 2 dentists.(Counter-claim to 1,2, 3, above)

February -August 1999.
Claimant 6 months sickness due to Mr Fergusons conduct.

January 2000.
Grievance dismissed by Jill Prendergast (Manager).

21 June 2000.
Jill Prendergast meets Claimant & gives copies of the nurse's statements. No action taken-letter. (Nurses reassured-no longer have to work with Claimant).

3 July 2000.
Jill Prendergast meets Claimant and tells her to stop canvassing for statements.

1 September 2000.
Formal disciplinary procedure-Claimant Suspended.

8 March 2001.
Disciplinary Investigation Report.
Recommends-referral to a Disciplinary Hearing.

2 & 3 May 2001.
Disciplinary Hearing decision-Claimant should be Dismissed.

4 & 5 September 2001.
Appeal of above decision & Full re-hearing.

7 September 2001.
Letter informs Claimant-the dismissal decision was upheld.

October 2002.
Claimant has a campaign for an Investigation;
Writes to the Press, MP. General Dental Council,
Chief Executives' of Trusts.

January 2003.
Final letter from the Chief Executive of the Strategic Health Authority

12 June 2003.
First Action-Newcastle County Court.
Defendant is Newcastle Primary C.NHS Trust.

10 November 2003.
Second Action-First Defendant is Newcastle PC. NHS T. **&** large number of individual employees or officers of the Trust are also Defendants.

7 June 2005.
The two Actions have been ordered to be tried together.

20 June - 11 April 2006.
High Court (QBD).Claims in both actions-Dismissed.
Permission to Appeal-Refused.
(The analysis covers the details of this Hearing)

2 March 2007.
Supreme Court of Judicature Court of Appeal.
Appeal refused.

APPENDIX 5. GENEALOGY OF EXISTENTIALISM.

Forerunners;

Biblical Text (St Paul c3-c66)
St.Augustine (354-386)
St Thomas Aquinas (1225-1274)
Socrates (469-399BC)
Michel Eyquem de Montaigne (1533-1592)
Blaise Pascal (1623-1662)

Time-frame	Philosophy;	Theology;	Literature;	Psychology;	Art;
1800	Søren Kierkegaard (1813-1855) Friedrich Wilhelm Nietzsche (1844-1900)		Fyodor Dostoyevsky (1821-1881) Friedrich Wilhelm Nietzsche (1844-1900)		Paul Cezanne (1839-1906)
1850	Edmund Husserl (1859-1938) Karl Jaspers (1883-1969) **(T)** Martin Heidegger (1889-1976)	Nikolay Berdyayev (1874-1948) **(P)** Martin Buber (1878-1965) Rudolf Bultmann (1884-1976) Paul Tillich (1886-1965) Gabriel Marcel (1889-1973)	Franz Kafka (1883- 1924)	Carl Jung (1875-1961) Jacob Moreno (1889-1974)	Alberto Giacomette Henri Michaux Francis Gruber
1900	Jean Paul Sartre (1905-1980) Simone De Beauvoir (1908-1986) Maurice Merleau-Ponty (1908-1961) Albert Camus (1913-1960)		André Malraux (1901-1976) Jean Paul Sartre (1905-1980) Samuel Beckett (1906-1989) Eugène Ionesco (1909-1994) Albert Camus (1913-1960) Arthur Miller(1915-2005) Walker Percy (1916-1990) **(K)** Norman Mailer (1923-) John Updike (1932-) **(K)** John Barth (1930 -)	Erich Fromm (1900-1980) Carl Rogers (1902-1987) Victor Frankl (1905-1997) **(E)** George Kelly (1905-1967) **(Phn)** Abraham Maslow (1908-1970) Rollo May (1909-1994) **(E)** Ronald Laing (1927-1989)	

T=Philosophy of Transcendence influenced Theology
P= Philosopher
K= Kierkegaard. Traces of his thought.
E=Existentialist Psychology
Phn=Phenomenology